

**Provider
Billing
and
Procedures
Manual**

REVISION HISTORY

Version	Revision Date	Revision Page Number(s) and/or Section Name	Reason	Reviser
5.0	February 2013	NA	Initial document based on previous Provider Billing and Procedures Manual	Publications Team
5.1	April 2013/ February 2013	<p>Updated the following pages (sections):</p> <ul style="list-style-type: none"> • 2-15 (Medicaid on the Web/Secure Site) • 4-34 (Secure Site Eligibility Verification) • 4-38 (Accessing the Secure Web Site) • 4-39 (Getting to the Secure Web Site) • 4-43 (Broadcast Messages; was Global Messages) • 4-43 (Main Page) • 4-44 (Performing a Claim Inquiry) • 4-45 (Resubmit Claim-Denied Claims Only and Void Claim-Paid Claims Only) • 5-46 (Eligibility Page) • 5-47 (Pricing Page, Prior Authorization Page, and Prior Authorization Submission) • 5-48 (Prior Authorization Inquiry and Prior Authorization Summary) • 5-49 (Prior Authorization Notices and Additional Tidbits for Successful Use) • 5-51 (Trade Files Page) • 5-55 (Mailbox Page) • 5-56 (Help Page and Logout Page) • 6-70 (Direct Data Entry (DDE) Claim Submission – Professional) • 6-84 (Direct Data Entry (DDE) Claim Submission – Institutional) • 6-97 (Direct Data Entry (DDE) Claim Submission – Dental) • 6-107 (Direct Data Entry (DDE) Claim Submission – Pharmacy (Including Compounds)) <p>Changed “ICN link” to “Claim ID” throughout.</p>	Updated for the new SoonerCare Provider Portal DDI Enhancement	Adrian Barron

Version	Revision Date	Revision Page Number(s) and/or Section Name	Reason	Reviser
5.1		Updated the following pages (sections): <ul style="list-style-type: none"> • 2-45 (Available Services) • 5-41 (Account Initialization) • 5-41 (Register Now – was Register Now) • 5-43 (Types of Web Users – removed levels) • 5-45 (Switch Provider) • 5-46 (Claim Inquiry) • 5-46 (Performing a Claim Inquiry) • 5-49 (Care Management Page – was Prior Authorization Page) • 5-51 (Trade Files Page (BATCH SUBMISSION)) • 5-53 (File Download) • 5-44 (Forgot Password) • 5-54(Manage Account Page – was Accounts Maintenance Page) • 5-55 (Adding a New Clerk – was Billing Agent or Clerk) • 5-55 (Add Registered Clerk and Add Registered Billing Agent are new sections) • 5-56 (Revising Billing Agent or Clear Access) • 5-56 (Designate Billing Agent – was Level 1A (Billing Agent)) • 5-56 (Clerks and Billing Agents – was Level II Clerks) • 5-56 (Broadcast Messages – was Mailbox Page) • 5-57 (Help Page) • 6-71 (Screen Sample 6.1) • 6-74 (DDE Professional Claim Submission Instructions table) • 6-85 (Screen Sample 6.3) • 6-86 (Screen Sample 6.4) • 6-88 (DDE Institutional Claim Submission Instructions table) • 6-99 (DDE Dental Claim Submission Instructions table) • 6-107 (Direct Data Entry (DDE) Claim Submission – Pharmacy (Including Compounds) screen shots. • 6-109 (Pharmacy Claim Submission Instructions table) • 7-112 (Section F, Helpful Tips) 		Adrian Barron
5.2	06/13/2013	<ul style="list-style-type: none"> • Various – Added information about using the My Profile-Role Qualifiers from the billing agent user account, when the agent code is unknown. 	Additional updates for the new SoonerCare Provider Portal DDI Enhancement	

Version	Revision Date	Revision Page Number(s) and/or Section Name	Reason	Reviser
		<ul style="list-style-type: none"> • Various – Changed “ICD-9” to “ICD” and “ICD-9-CM” to “ICD-CM.” 		
5.3	07/05/2013	<ul style="list-style-type: none"> • Throughout – Updated “Secure Site” and “Medicaid on the Web” to “SoonerCare Provider Portal”. • 4-36 (SoonerCare Provider Portal Eligibility Verification) • 5-44 (Types of Web Users) 	Changes made per internal HPES review comments.	Adrian Barron
5.4	08/13/2013	<ul style="list-style-type: none"> • Global (Updated misspellings and formatting) • Global (Updated hyperlinks as needed) • Global (Updated submit claim screen shots to remove PHI) • 5-40 (Updated browser requirements) • 5-46 (Pharmacy Claims cell) 	Changes made per internal work product review (WPR) on 08/05/2013.	Provider Portal team
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5.6	3/09/2015	<ul style="list-style-type: none"> • Updates made to reflect new form (ADA 2012) • Chp.1 updated to reflect updates to Quick Reference Guide. 		

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Chapter 1

General Information



INTRODUCTION

The Oklahoma Health Care Authority (OHCA) is the state agency responsible for the administration of the Oklahoma Medicaid program. The OHCA has a contractual agreement with HP Enterprise Services (HPES) to be the fiscal agent for the Oklahoma Medicaid program. The OHCA's primary objective is to maintain a system to accurately and effectively process and pay all valid Oklahoma Title XIX Medicaid program provider claims.

This publication is the primary reference for submitting and processing claims, prior authorization requests, remittance advice and other related documents. This manual is not a legal description of all aspects of Medicaid law. This manual is intended to provide basic program guidelines for providers that participate in the Oklahoma Medicaid program.

A provider's participation in the Oklahoma Medicaid program is voluntary. However, providers that choose to participate in Medicaid must accept the Medicaid payment as payment in full for services covered by Medicaid. The provider is restricted from charging the Medicaid member the difference between the usual and customary charge, and Medicaid's payment. Services not covered under the Medicaid program can be billed directly to the member. *Every effort has been made to ensure this manual's accuracy*, if there are any instances where the guidelines appear to contradict relevant provisions of the Oklahoma Medicaid policies and rules, the policies and rules will prevail. This manual does not take precedence over federal regulation, state statutes or administrative procedures. The OHCA and HPES developed this manual for Oklahoma Medicaid providers.

The Provider Billing and Procedure Manual will receive periodic reviews, changes and updates. The online version of this manual is the most current version and is available at the OHCA Web site at www.okhca.org. Once there, select Provider, Policies & Rules link, scroll down to Guides & Manuals and select the Oklahoma Medicaid Provider Billing & Procedures Manual link. Providers issued print and CD copies of this manual will not automatically receive an updated version.

SECTION A: OHCA WEB SITE

The OHCA administers the state of Oklahoma's Medicaid agency program known as SoonerCare. Primary programs under SoonerCare include: SoonerCare Traditional, SoonerCare Choice and Sooner Plan. The OHCA Web site at www.okhca.org (see Screen Sample 1.1) provides information for Medicaid members and providers with data on programs, and health and medical policies.



Screen Sample 1.1

OHCA Web Pages

Calendar: The Calendar page can be used to find dates and details on training, meeting and other upcoming events.

Contact Us: Use the Contact Us page to find everything from OHCA addresses and telephone numbers to driving directions to the OHCA office.

Provider: The Provider page has information on becoming a Medicaid provider, provider-type details, claim management tools, program reference resources, rule and policy data, free training

opportunities and updates on what is new in SoonerCare.

Publications: The Publications page has links to most OHCA publications, forms and OHCA information on statistical reports and data.

SECTION B: GENERAL CONTACT INFORMATION

OHCA Call Tree

Toll free: 800-522-0114, or in Oklahoma City area: 405-522-6205

Option	Unit	Call Types	Availability
1	OHCA Call Center	Member billing questions, eligibility inquiries or policy questions	8 am – 5 pm M-F
2, 1	Internet Help Desk	Internet PIN resets or assistance with the SoonerCare Provider Portal	8 am – noon & 1 pm – 5 pm M-F
2, 2	EDI Help Desk	Batch transactions assistance	8 am – noon & 1 pm – 5 pm M-F
3, 1	Adjustments	Paid claim adjustments or outstanding A/R inquiries	7:30 am – 4 pm M, W, Th, F 12 pm – 4 pm Tues.
3, 2	Third Party Liability	Health insurance injury/accident questionnaires, third party insurance inquiries, estate recovery or subrogation issues	8 am – 5 pm M-F
4	Pharmacy Help Desk (issues)	Pharmacy issues	8:30 am – 7 pm M-F 9 am – 5 pm Sat. 11 am – 5 pm Sun.
5	Provider Contracts	Provider contracts	8 am – 5 pm M-F
6, 1	Pharmacy Help Desk (authorizations)	Pharmacy authorizations	8:30 am – 7 pm M-F 9 am – 5 pm Sat. 11 am – 5 pm Sun.
6, 2, 1	Behavioral Health Authorization (OP)	For Out-Patient Behavioral Health authorizations	8 am – 5 pm M-F
6,2,2	Behavioral Health Authorization (IP)	For In-Patient Behavioral Health authorizations	8 am – 5 pm M-F
6, 3	Medical Authorizations (status)	Medical authorization status	8 am – 5 pm M-F
6,4	Prior Authorizations	For prior authorizations for DME, medical services and emergency services for	8 am – 5 pm M-F

		aliens	
6, 5	Dental Authorizations	Dental authorizations (status only)	8 am – 5 pm M-F

Paper Claim Mailing Addresses:

Form UB-04 (Hospital or Home Health)	HP Enterprise Services PO Box 18430 Oklahoma City, OK 73154
Medicare Crossovers (UB, 1500) or Dental (ADA)	HP Enterprise Services PO Box 18110 Oklahoma City, OK 73154
Form 1500	HP Enterprise Services PO Box 54740 Oklahoma City, OK 73154
HMO Co-pay/Personal Care Services (Individual; not agency)	HP Enterprise Services PO Box 18500 Oklahoma City, OK 73154
Long Term Care Nursing Facilities	HP Enterprise Services PO Box 54200 Oklahoma City, OK 73154
Pharmacy	HP Enterprise Services PO Box 18650 Oklahoma City, OK 73154
Waiver Provider	HP Enterprise Services PO Box 54016 Oklahoma City, OK 73154

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Chapter 2

SoonerCare Programs



INTRODUCTION

In order to be eligible to participate in Oklahoma SoonerCare programs, providers must have an approved provider agreement on file with the OHCA. Through this agreement, the provider certifies all information submitted on claims is accurate and complies with all applicable state and federal regulations. This agreement is effective once the provider signs the agreement, and the OHCA reviews and approves the agreement.

SECTION A: PROVIDER POLICIES

A provider is any individual or facility that qualifies and meets all state and federal requirements, and has a current agreement with the OHCA to provide health-care services under SoonerCare or other OHCA-administered medical service programs.

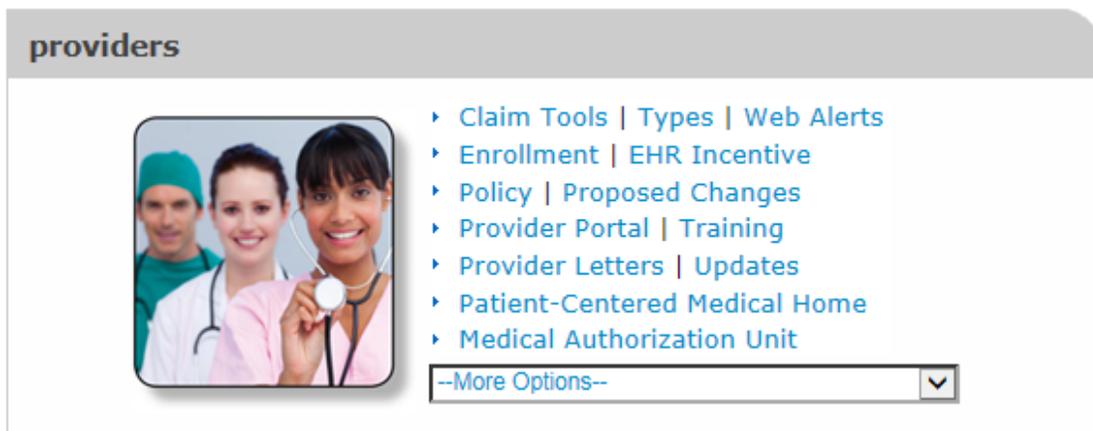
Payments

Payments to providers under SoonerCare are made for services identified as personally rendered services performed on behalf of a specific patient. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

Payments are made on behalf of SoonerCare eligible individuals for services within the scope of the OHCA's medical programs. Services cannot be paid under SoonerCare for ineligible individuals, services not covered under the scope of medical programs or services not meeting documentation requirements. These claims will be denied or payment will be recouped, in some instances upon post-payment review.

Link-Up To OHCA

For additional information on provider policies, go to www.okhca.org, select the Policy link (see Screen Sample 2.1). When the page appears, select the Oklahoma Health Care Authority Medical Rules link, and then select the Chapter 30 link.



Screen Sample 2.1

SECTION B: PROVIDER FILE MAINTENANCE

Provider agreements must be renewed every three years. It is the responsibility of the provider to maintain records and agreements with the OHCA.

All information changes including address, phone number, bank (including electronic funds transfer data) and group member changes must be promptly reported. Failure to maintain current provider information can result in delay or denial of payments for services rendered. Changes for all provider record information should be made through the OHCA SoonerCare Provider Portal.

For additional information on provider enrollment criteria, call the OHCA toll-free in state at 800-522-0114 (option 5), or out of state at 405-522-6205 (option 5). You can also go to www.okhca.org, select the Enrollment, New Contracts link, and then select the appropriate option.

SECTION C: PROVIDER SERVICES

Eligibility Verification System (EVS)

The EVS system is available from 5:00 am to 1:00 am. Access the information by entering the provider's SoonerCare ID number and the alpha-character location code, as well as your 4-digit PIN. If you do not have a PIN, please call 1-800-522-0114 (option 2, option 1).

The automated voice response (AVR) system provides a nationwide toll free telephone number to help providers obtain

pertinent information. Providers are able to enter information on a touch-tone phone or by the AVR speech application.

Available Services

The following is a list of information that can be obtained through the AVR:

- Member eligibility with fax back capabilities
- Provider warrant information
- Prior authorization with fax back capabilities
- Claim status inquiry

More information regarding the EVS can be found in the Member Eligibility Verification chapter of this manual

EVS Phone Numbers

Nationwide toll free: 800-767-3949

Oklahoma City metro area: 405-840-0650

Computer Telephony Integration

Computer Telephony Integration (CTI) allows providers to enter information – such as name, provider number and location – through the AVR system. The information is captured and sent to the appropriate provider service coordinator. The provider representative enters notes and questions from the provider into the call tracking system, so if a call must be transferred the provider's information will be captured and available to the next representative.

Call Centers

The OHCA is committed to providing customer service to the provider community, members and other interested parties. OHCA Call Center representatives answer inquiries regarding eligibility, warrant information, proper billing procedures, prior authorization and SoonerCare policy for providers as well as members.

OHCA Provider Services closely interacts with the HPES Provider Relations staff to resolve training issues related to the Oklahoma SoonerCare program. Provider Services and HPES Provider Relations act as intermediaries for providers, members and others by resolving billing or adjudication problems requiring additional information or research.

Provider Inquiries

Telephone inquiries are received between 8:00 am and 5:00 pm, Monday through Friday. (Pharmacy Help Desk is available extended hours seven days/week.)

Available Services

Information available to the provider through the call tree options include:

- Policy Questions
- Pharmacy Help Desk
- Provider Contracts
- Adjustments
- Third Party Liability (TPL)
- PIN resets
- Prior Authorization
 - Medical
 - Dental

Before You Call

When calling OHCA Provider Services or the OHCA Call Center, **have the following information available** to expedite the research of the inquiry:

- ✓ The 10-character (nine numbers, alpha character) SoonerCare provider number
- ✓ The SoonerCare member's ID number
- ✓ The date(s) of service
- ✓ The billed amount

Members Inquiries

When inquiring by telephone, please call between 8:00 am and 5:00 pm, Monday through Friday.

Phone Numbers

Members toll-free: 800-522-0310

Oklahoma City metro area: 405-522-7171

Available Services

Information available for the members through the call tree options include:

- Eligibility.
- Claim status.
- SoonerCare Member Services.
- Pharmacy Help Desk
- Enrollment Agent.
- Spanish assistance 8:00 am – 5:00 pm M-F.

SoonerCare Provider Field Representatives

SoonerCare has a team of regional field representatives with in-depth knowledge of Oklahoma SoonerCare billing requirements and claim-processing procedures. Training is offered on billing, EVS and AVR, Electronic Data Interchange (EDI), and the SoonerCare Provider Portal SoonerCare Provider Portal. Field consultants provide training through on-site visits and workshops. They encourage providers to use electronic claim submission because it's fast, easy to use and saves money.

Training Objectives

The focus of a field representative is to

- Train newly enrolled providers
- Contact and visit high-volume providers
- Conduct provider training workshops

Providers may contact their field consultant by telephone to request a visit for training at the provider's location. Field representatives are responsible for arranging their own schedules. They are available Monday through Friday for on-site provider visits. Provider on-site visits are normally scheduled two weeks in advance. Since field consultants are often out of the office, please allow a minimum of 48 hours for telephone calls to be returned.

Provider Workshops

Field representatives are responsible for the development and presentation of educational workshops about all procedural aspects of the Oklahoma Medicaid Management Information System (OKMMIS).

OHCA and HPES presents scheduled workshops throughout the year to educate providers on Oklahoma SoonerCare claim processing procedures. Workshops are announced in bulletins, newsletters and on the OHCA Web site at www.okhca.org. Group training can also be arranged at the request of individual provider groups or associations.

Be Prepared

The following information should be provided to assist your field consultant in planning the visit or workshop:

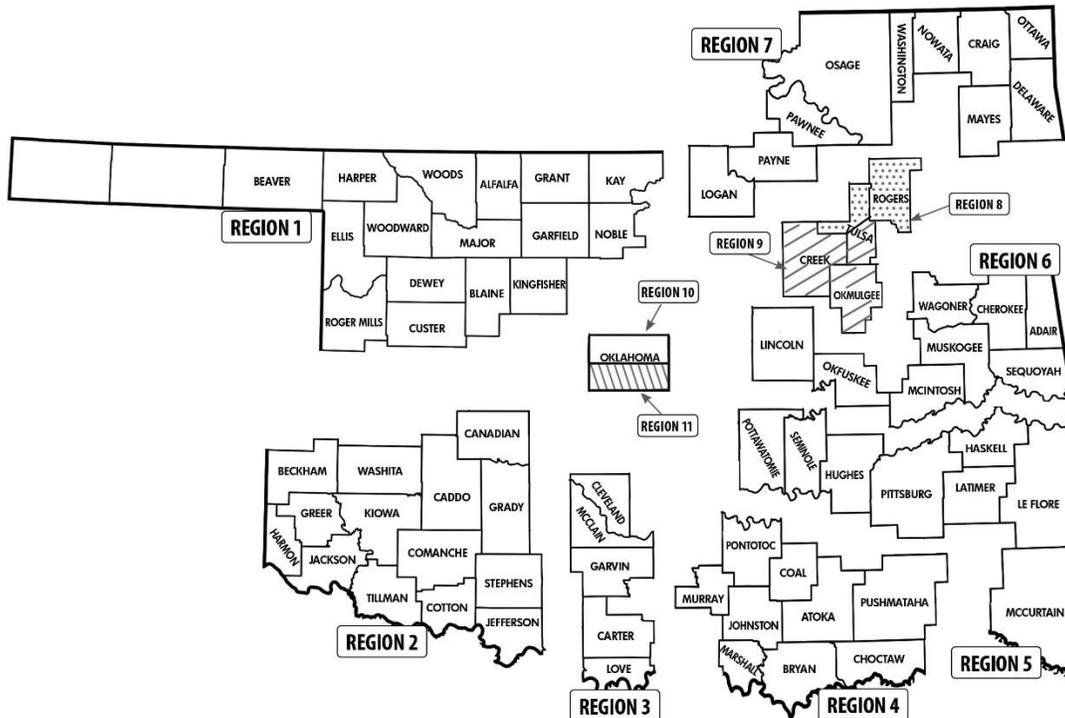
- ✓ Provider type and specialty attending the seminar
- ✓ Number of attendees
- ✓ Time and location of the event
- ✓ Issues to be addressed
- ✓ Point of contact, in case additional information is needed prior to the event

HPES and OHCA Field Representatives Contact Information

Region	Phone Number	Counties within the Region
1	405-416-6715	Alfalfa, Beaver, Blaine, Cimarron, Custer, Dewey, Ellis, Garfield, Grant, Harper, Kay, Kingfisher, Major, Noble, Roger Mills, Texas, Woods, Woodward
2	405-522-7847	Beckham, Caddo, Canadian, Comanche, Cotton, Grady, Greer, Harmon, Jackson, Jefferson, Kiowa, Stephens, Tillman, Washita
3	405-416-6720	Carter, Cleveland, Garvin, Love, McClain
4	405-416-6763	Atoka, Bryan, Choctaw, Coal, Johnston, Marshall, Murray, Pontotoc, Pushmataha
5	405-522-7349	Haskell, Hughes, Latimer, Le Flore, McCurtain, Pittsburg, Pottawatomie, Seminole
6	405-522-7034	Adair, Cherokee, Lincoln, McIntosh, Muskogee, Okfuskee, Sequoyah, Wagoner
7	405-416-6739	Craig, Delaware, Logan, Mayes, Nowata, Osage, Ottawa, Pawnee, Payne, Washington
8	405-522-7132	Rogers, Tulsa County <i>north of I-44</i>
9	405-416-6716	Creek, Okmulgee, Tulsa County <i>south of I-44</i>

Region	Phone Number	Counties within the Region
10	405-416-6740	Oklahoma County north of 23 rd St.
11	405-522-7154	Oklahoma County south of 23 rd St.
Out-of-State Consultant: 405-416-6721		

Regional Map



SoonerCare Provider Portal

The SoonerCare Provider Portal is the OHCA’s secure Web site, offering providers a number of services from submitting claims on the Web to fast verification of claim status. New providers are assigned a PIN to access the Web site.

To access the page, go to www.okhca.org, select the Providers tab and select the Secure Sites link. For more information on logging in for the first time and entering the SoonerCare Provider Portal, look under the Help tab on the Web site. The SoonerCare Provider Portal is available 24 hours a day, 7 days a week, except during scheduled maintenance.

Available Services

The following services are available to the SoonerCare Provider Portal users:

- Global messaging (can be specific to one or all providers)
- Claims submission
- Claims inquiry
- Prior authorization submission
- Provider PA notice
- Prior authorization inquiry
- Procedure pricing
- View Payment History
- View/Download Remittance Advice
- Eligibility verification
- Managed Care rosters
- Provider File Updates

SECTION D: WRITTEN INQUIRIES

When inquiring in writing about the status of a SoonerCare claim, use the SoonerCare Claim Inquiry/Response form HCA-17. A sample of this form is found in the Forms chapter of this manual. Follow the instructions on the form. Attach a copy of the original claim and any supporting documentation, such as a copy of the remittance/denial, PCP/CM referral, Medicare EOMB, consent forms or medical records required for review.

Mail Inquiry/Response forms, policy questions and any other written correspondence regarding hard-to-resolve SoonerCare claims to:

OHCA

Attention: Provider Services
P.O. Box 18506
Oklahoma City, OK
73154-0506

Mailing Claims

Original, corrected and re-filed claims are submitted to the fiscal agent at the appropriate address listed in the General Information chapter of this manual. Claims mailed to addresses other than the

assigned PO Box might result in payment delays. For a list of mailing addresses, see the General Information chapter of this manual.



Chapter 3

SoonerCare Choice



INTRODUCTION

SoonerCare Choice is Oklahoma's Medicaid Managed Care program. The program began in 1996 in 61 rural counties in Oklahoma. It was expanded statewide in April 2004 to include urban counties that had been previously covered under the SoonerCare program. The Choice program provides primary and preventive health care services. Health care is provided and managed by a Primary Care Provider/Case Manager (PCP/CM) that contracts to be a medical home for members on their panel. The level of medical home determines the care coordination payment the PCP receives. All other services are paid based on the OHCA current FFS payment methodology. PCPs may also qualify for SoonerExcel incentive payments based on individual performance. Physicians, nurse practitioners and physician assistants in primary care specialties can contract as PCP/CMs.

Quality Assurance

The OHCA is committed to ensuring that high quality health care is always available to its members. SoonerCare Choice providers agree to cooperate with external review organizations, internal reviews and other quality assurance efforts.

Quality Assurance (QA) Tools

Quality assurance measures may include:

CAHPS Report Card

Annual telephone and mail surveys of SoonerCare Choice members are conducted by an external review organization, which measures health care satisfaction, including care provided by their PCP/CM.

After-Hours Surveys

Telephone surveys are conducted by the OHCA or one of its agents to ensure that PCP/CMs provide information concerning after-hours access to medical information or a medical professional.

Member Reports

Member calls to the SoonerCare Helpline for issues regarding quality of care or access to care needs are documented and forwarded to the OHCA for research and/or resolution.

On-Site Audits

On-site audits are conducted by OHCA Quality Assurance/Quality Improvement staff.

Encounter Data Reviews

Data reflecting medical care use rates, preventive care services and referral patterns are reviewed and analyzed. This information is used in determining use patterns, referral patterns, rate setting and other reporting purposes.

Emergency Room Utilization Profiling

OHCA Quality Assurance/Quality Improvement staff perform quarterly analysis of PCP/CM office encounter claims submission versus emergency room claim submission. The results of these reports are forwarded to the PCP/CMs as well as SoonerCare Provider Services. The goal of this project is to reduce inappropriate use of emergency rooms.

SECTION A: COVERED MEMBERS

The Oklahoma Health Care Authority determines eligibility for most SoonerCare members through our On-Line Enrollment System. This system is a secure web based application process that provides real time eligibility for members who have internet access. Paper applications also remain an option for members who do not have computer internet access. The Oklahoma Department of Human Services (OKDHS) continues to determine eligibility for some SoonerCare programs. Members must meet financial, residency, disability status and other requirements before they can become eligible for SoonerCare.

SoonerCare Choice covers members who qualify for medical services through the Temporary Aid to Needy Families (TANF) program or those who qualify due to age or disability. Members may also include women who have been diagnosed with breast or cervical cancer under Oklahoma Cares, or children with disabilities who qualify under the Tax Equity and Fiscal Responsibility Act (TEFRA).

Native Americans

Native Americans who are eligible for SoonerCare Choice must enroll with a Primary Care/Case Manager. They may choose a traditional SoonerCare Choice provider or enroll with an Indian

Health Service, Tribal, or Urban Indian (I/T/U) clinic provider that participates in the program. All Native American members have the option to self-refer to any I/T/U facility for services that can be provided at these facilities.

SoonerCare Choice Exempt

Most members who are eligible for SoonerCare benefits will be enrolled in the SoonerCare Choice program. Individuals exempt from this mandate are:

- Eligible for Medicare and SoonerCare Traditional
- Enrolled in a waiver program, (examples being. Advantage or Home/Community waiver)
- Residing in a long-term care center or institution
- Individuals with other forms of credible health insurance coverage.
- Subsidized adoption
- State or Tribal custody

SECTION B: ACCESS TO CARE

SoonerCare Choice PCP/CMs are required to maintain access to primary and preventive care services in accordance to its contract. The following standards apply:

1. PCP/CMs must maintain 24 hour, seven day per week telephone coverage, which will either page an on-call medical professional or give alternate information to members concerning who they can contact to obtain medical advice.
2. PCP/CMs must offer hours of operation that are no fewer than the hours of operation offered to commercial patients or SoonerCare Traditional members.
3. PCP/CMs must provide medical evaluation and treatment within 24 hours for urgent medical conditions. Generally, urgent care is for sudden illnesses or injuries where there is no immediate danger of death or permanent disability.
4. PCP/CMs can charge the appropriate co-payment to Choice members ages 21 and over. PCP/CMs may not deny services based on the member's inability to pay the appropriate co-payment.

Emergency Care

PCP/CMs are not required to provide emergency care either in its office or in an emergency room. PCP/CMs that do provide emergency care in the emergency room will be reimbursed based on current OHCA policy.

PCP/CMs should not refer members to an emergency room for non-emergency services. Providers should interact with their assigned members to discourage inappropriate emergency room use. PCP/CMs should manage follow-up care from the emergency room, as needed.

SECTION C: MEMBER ENROLLMENT/DISENROLLMENT

SoonerCare Choice Enrollment

SoonerCare member benefits start when eligibility for SoonerCare is determined.

The effective date of SoonerCare Choice members' benefits depend on the certification date. Always check the Eligibility Verification System (EVS) either by calling the toll-free EVS line, through the swipe machine or on the SoonerCare Provider Portal.

NOTE: *Medical care during the time a member is eligible for SoonerCare Traditional, but not yet effective in SoonerCare Choice, will be covered under the SoonerCare Traditional fee-for-service program.*

Continuing eligibility for SoonerCare benefits must be recertified periodically. The recertification intervals vary according to the type of assistance members receive. SoonerCare members are notified in writing by DHS prior to the expiration of benefits.

Breaks in eligibility may mean a disruption in continuity of care. If the PCP/CM's capacity is limited in comparison to demand, the member may not be able to regain his or her place on that PCP/CM's panel.

Members may reenroll with a PCP/CM by calling the SoonerCare Helpline if they have a break in eligibility and are being recertified. Members who lose and regain eligibility within 365 days are assigned to their most recent PCP/CM, if the PCP/CM has available capacity and of the member's age is within the PCP/CM's scope of practice.

Choosing a PCP/CM

The OHCA offers all members the opportunity to choose a PCP/CM from the provider directory. If a member does not choose a PCP/CM, the OHCA will contact the member to assist them in choosing a medical home. If a member seeks care prior to choosing a medical home the provider seeing the member will be the medical home.

Families with more than one eligible member are allowed to choose a different PCP/CM for each eligible member.

Enrollment with a PCP/CM takes effect on the day the selection is made. Prior to the first day of each month, the OHCA provides the PCP/CM with a SoonerCare Choice eligibility listing of new enrollees and continuing members.

Capacity (Number of Members requested per PCP/CM)

The PCP/CM specifies the maximum number of members he or she is willing to accept. The maximum number is 2,500 members for each physician PCP/CM. The maximum capacity for physician assistants and nurse practitioners serving as PCP/CMs is 1,250. The PCP/CM must agree to a minimum panel of 50 members. The OHCA cannot guarantee the number of members a PCP/CM receives.

A PCP/CM may request a change in its capacity by submitting a written request to the Provider Enrollment division of the OHCA. If approved, the OHCA will implement the change on the first day of the month with sufficient notice.

If a PCP/CM requests a lower capacity - within program standards and it is approved by the OHCA - the reduction in members will come through members changing PCP/CMs or losing eligibility. Members will not be disenrolled to achieve a lower capacity.

Changing PCP/CMs

The OHCA or the SoonerCare Helpline may change a member from one PCP/CM to another PCP/CM for the following reasons:

- Member can request change without cause
- When a PCP/CM terminates his or her participation in the SoonerCare Choice program

Disenrollment At The Request of the PCP/CM

The OHCA may also change a member from the assigned PCP/CM to another PCP/CM for good cause and upon written request of the

assigned PCP/CM. If the request is a good cause change, the OHCA will act upon the request within 30 days of receipt from the OHCA SoonerCare Choice division.

Good cause is defined as:

- Non-compliance with PCP/CM's direction
- Abuse of PCP/CM and/or staff (includes disruptive behavior)
- Deterioration of PCP/CM- member relationship
- Excessive no-show appointments above the PCP/CM office policy limit

The dismissal request and supporting documentation should be forwarded for processing to SoonerCare at 405-530-3228. Members may not be notified by the PCP/CM until approval for disenrollment is granted by the OHCA.

Either party has the right to appeal the decision to the administrative law judge, pursuant to OAC 317:2-1-2 (Authority's Grievance Procedure)

SECTION D: REFERRALS

SoonerCare Choice referrals:

- Made on the basis of medical necessity as determined by the PCP
- Required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP/CM
- Must have the correct provider referral number to ensure payment to the referred to provider (provider/referral numbers are site specific)

Referrals must be signed by the PCP/CM or a designee within the PCP/CM's office who is authorized to sign for the provider.

Some services may also require prior authorization. It is up to the referred to provider, or provider ordering services, to obtain prior authorization as needed. Prior authorization for services is obtained through the Medical Authorization Unit at OHCA or one of its agents.

SoonerCare Choice referrals must be made if the member requests a second opinion when surgery is recommended. Following the second opinion, any treatment received by the member is to be rendered by the PCP or through a referral made by the PCP/CM.

SoonerCare Choice referrals may be made to another PCP/CM for services equal to those of a specialist. Examples of this are, a family practitioner could refer to another family practitioner who performs a surgical procedure, or a general practitioner could refer to an internist who manages complicated diabetic patients.

SoonerCare Choice referrals may be made to a provider for ongoing treatment for time specified by the PCP/CM, but limited to 12 months. For the duration of the referral, the referred-to provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

SoonerCare Choice referrals are not required for:

- Child physical/sexual abuse exams
- Services provided by a PCP/CM for members enrolled or assigned to the PCP/CM
- Emergency room care
- Obstetrical care
- Vision screenings for members younger than 21 years
- Basic dental for members younger than 21 years (benefit is limited to emergency extractions for members older than 21 years)
- Behavioral/mental health
- Family planning
- Inpatient hospital services
- Routine laboratory and x-ray
- Services provided to Native Americans in a tribal, IHS or Urban Indian Clinic facility

Payment of Referred Services

Payment for referred services is subject to coverage limitations under the current SoonerCare reimbursement policies. Payment for referred services is limited to four specialty visits per month for adults older than 20 years of age. Visits to their PCP/CM are excluded from this limitation. To ensure payment, PCP/CMs must refer only to SoonerCare providers that have an active SoonerCare Traditional contract.

Documenting the Medical File

Documentation in the medical record should include a copy of each referral to another health care provider and any additional

referrals made by the referred-to provider when this information is known. An example might be ancillary services.

Documentation in the medical record should include a medical report from the referred-to provider. The referred to provider should report their findings to the referring PCP/CM within two weeks of the member's appointment. In the event a medical report is not received within a reasonable time, the PCP/CM should contact the referred-to health care provider to obtain this information.

Unauthorized Use of Provider Number

Unauthorized use of a SoonerCare Choice NPI or legacy number may result in official action to recover unauthorized reimbursements from the billing provider.

Referral Form and Instructions

In the SoonerCare Choice program, the PCP/CM is responsible for providing primary care and making specialty referrals. The PCP/CM completes the referral form, including the referral number. The PCP/CM's SoonerCare Choice NPI and legacy number serves as their referral number. The provider/referral number is site specific and must be for the site where the member is enrolled or assigned. The referral includes ancillary services rendered, or required, by the referred to specialist.

With the PCP/CM's approval, a specialist may relay a copy of the original referral to other specialists with instructions considered necessary for proper member treatment. Payment is subject to the current SoonerCare reimbursement policies.

The provider mails the original of the completed form to the specialist, or referred to provider. A copy of the form is retained in the patient's medical record.

When a claim is submitted by a referred to provider, the referral number must be entered in box 17a of the 1500 professional claim form, or box 30 of the UB-04 institutional claim form. A copy of the referral should not be attached to the claim. If the referral number is not on the claim form, payment will be denied unless for self-referred services are provided.

The SC-10 referral forms can be accessed and printed from the Forms page on the OHCA Web site at www.okhca.org.

SECTION E: EPSDT

Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program and one of the highest priorities of the SoonerCare Choice program. EPSDT is designed to provide a comprehensive program of preventive screening examinations, dental, vision, hearing and immunization services to SoonerCare Choice members age 20 or younger.

Schedule of EPSDT Services

As a minimum, the following schedule for EPSDT screening is required:

- Six visits during the first year of life
- Two visits in the second year of life
- One visit yearly for ages two through five
- One visit every other year for ages six through 20
- Metabolic lead screen at ages one and two; or six years old if not done by age 2. *This is mandatory*

Additional Requirements

The OHCA requires contractors to:

- Conduct and document follow-up appointments with all members younger than 21 years old who miss appointments
- Administer outreach, including telephone calls or printed notification mailed to a member when a health care screen is indicated or missed. This ensures that all members who are age 20 or younger are current
- Educate families of members age 20 or younger about the importance of early periodic screening, diagnosis and treatment

EPSDT Bonus Payment

The OHCA offers bonuses to be paid to PCP/CMs that demonstrate a specified screening rate.

To qualify for the EPSDT bonus, verifiable encounter claim data must be submitted in a timely manner as set forth in the SoonerCare Choice contract (Section 6.2 for year 2007) and for any following contract addendums.

The OHCA may conduct onsite chart audits.

See the Reimbursement section below for further bonus payment details.

SECTION F: REPORTING REQUIREMENTS

Data, information and reports collected or prepared by the PCP/CMs in the course of performing its duties and obligations as a PCP/CM are owned by the state of Oklahoma. The OHCA and other appropriate entities reserve the right to examine this information upon request. This information includes medical and financial records, accounting practices, and other items relevant to the provider's contract.

The PCP/CM is required to report to the OHCA in writing and within a timely manner any changes to its SoonerCare Choice contract. The report must include demographic, financial and group composition information as reported in their contract.

Claims submitted by the PCP/CM should be submitted in the same manner and on the same claim forms used to submit claims for SoonerCare Traditional members. Encounter Claims must be submitted within 60 days from the date of services. Denied claims must be corrected and resubmitted within 60 days of adjudication.

SECTION G: REIMBURSEMENT

Care Coordination

SoonerCare Choice PCP/CMs are paid a care coordination payment for each member enrolled with them on a monthly basis.

Care Coordination payments vary according to the type of members the PCP services and their level of medical home status.

Care Coordination payments are made by the 10th working day of each month for all eligible members enrolled with the PCP/CM on the first of each month. A single monthly payment is generated and accompanies the Care Coordination Listing or is deposited directly.

Claims

PCP/CMs are required to file a claim with the OHCA each time a service is provided to a member. Claims filed will be paid subject to the current SoonerCare Traditional fee schedule and reimbursement policies.

Claims are to be submitted on the appropriate claim form within 60 days of the date the service was provided.

Immunization Incentive Payment

Immunization Incentive Payments are available when the PCP/CM provides written notice that it has administered the 4th dose of DPT/DTAP to a member before the member's second birthday.

SECTION H: PROVIDER RESOURCES

SoonerCare Provider Representatives

Provider representatives are available to all SoonerCare providers to answer questions or assist with policy issues, research complex claim issues and provide onsite training and support. These provider representatives can be reached by calling toll free at 800-522-0114, *option 1*. Provider representatives will be available to assist you with questions, claim resolution or directing you to your on-site provider representative.

HPES Field Consultants

HPES field consultants make onsite visits to assist providers with billing questions and train providers how to submit online claims through the OHCA Web site. The field consultants conduct training sessions every other month along with the spring and fall workshops. Providers can locate their HPES field consultant by visiting the OHCA Web site at www.okhca.org. Once there

1. Select the Provider link in the center of the page
2. Select the Training link under the Providers header on the left side of the next page
3. Select the HPES Field Consultants link on the right of the next page where you will find your field consultant.

Translation Services

The SoonerCare Helpline offers translation services 24 hours a day, seven days a week. If you cannot communicate with the member because of language, call the SoonerCare Helpline at 1-866-872-0807 and enter state code 53510.

Care Management

The Care Management Department is comprised of registered nurses and licensed practical nurses. These medical professionals assist in facilitating medical services for SoonerCare members with complex medical conditions.

Population Care Management Services

- Help members access care and services
- Assist providers with coordination of discharge planning
- Resolve issues and concerns with providers as related to medical care
- Help get approvals for medicines and medical services
- Provide patient education to identified groups
- Assist with coordinating community support and social service systems
- Offer out-of-state referrals if no comparable in-state services are offered or in cases of urgent care needs
- Complex medical conditions include
 - High Risk OB cases
 - Transplant cases
 - Catastrophic illness or injury
 - Women enrolled in the Breast and Cervical Cancer (BCC) program
 - Children who receive in-home Private Duty Nursing services (includes periodic home visits to evaluate & certify medically necessary services)

Provide support to SoonerCare providers for issues with:

- Care Management Referral forms
- High service utilization
- Medical regimen noncompliance
- Inappropriate ER visits
- Multiple providers/pharmacies
- Scheduled medication requests

- Refusing alternate treatments/prescriptions
- Refusing pain management referrals
- Drug seeking behaviors

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Chapter 4

Member Eligibility Verification



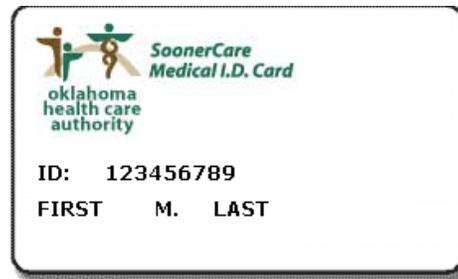
INTRODUCTION

SoonerCare (Oklahoma Medicaid) is a health coverage program jointly funded by the federal and state government which helps pay some or all medical bills for many people who can't afford them. The Oklahoma Health Care Authority (OHCA) is the state agency that administers the program and determines financial eligibility using federal poverty income guidelines. With the implementation of online enrollment in September 2010, members have the option of applying for SoonerCare online at www.mysooner.org.

Members have the option of applying for SoonerCare online or at their local county Oklahoma Department of Human Services (OKDHS) office.

SECTION A: MEMBER ID CARD

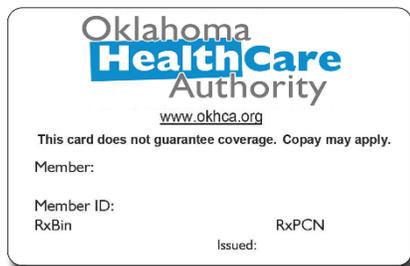
Medicaid SoonerCare members receive a permanent plastic identification card. The Medicaid Medical ID card is a white card with brown and green graphics. The card can be used for accessing the EVS system or a commercial swipe machine system to verify a member's eligibility before providing a Medicaid SoonerCare service. Shown below is an example of the medical ID card.



Old Version (Still Valid)



New Version



New Version



Members are encouraged to keep their card with them at all times; however, this card is not required to be provided by the member to receive services. Eligibility can be verified by using the member’s ID number from their card, member’s Social Security number with member’s date of birth, member’s first and last name along with date of birth or the member’s DHS case number; leaving off the 2-digit person code. It’s the provider’s responsibility to verify the member’s eligibility on a per visit basis to ensure the member’s continued eligibility for Medicaid SoonerCare coverage. Failure to verify eligibility prior to rendering services could result in a delay or denial of payment.

SECTION B: OPTIONS TO VERIFY MEMBER ELIGIBILITY

As an Oklahoma Medicaid SoonerCare provider, it is imperative that the member’s eligibility is verified before providing any services. Providers can check a member’s eligibility using one of four sources: Eligibility Verification System (EVS), the SoonerCare Provider Portal, swipe machines or Electronic Data Interchange (EDI). The purpose of the ID card is to give sufficient information to verify eligibility of the member. The card by itself is not a guarantee of eligibility. Providers need a Personal Identification Number (PIN) to access the Oklahoma Medicaid SoonerCare Provider Portal and the EVS. If a provider forgets their PIN, they can obtain it by calling the Internet Help Desk toll free at

800-522-0114 or within the Oklahoma City metro area at 405-522-6205 and selecting options 2 then 1.

EVS/AVR

The EVS provides a national toll-free telephone number to help providers obtain member eligibility, third party liability (TPL), warrant, prior authorization and claim inquiry information. Providers can also request prior authorization and eligibility fax backs. There are two ways to use the EVS system. A caller may use the touch-tone system or the automated voice response (AVR)/speech recognition system. A PIN is required to access member eligibility information. The four-digit PIN expires every six months. Providers may reset their PIN by staying on the phone and following the prompts.

Touch-Tone System

The touch-tone system allows a caller to go through the call by using the telephone's number pad. The caller's telephone must have touch-tone capability, as rotary style phones will not work on the touch-tone system.

Alpha Conversion

Entering the provider's SoonerCare ID number can access eligibility information. This will be a nine-digit number and the one alpha character location code that was assigned by the OHCA. A location conversion code has been established for the alphabet to be used in conjunction with the EVS. The codes are patterned to coincide with the location of numbers and letters on a telephone keypad. For example, the letter *A* converts to *21. The number 21 represents the second button and the first letter on the second button of the telephone keypad. The letter *R* converts to *72, representing the seventh button, third letter. See the alpha conversion chart below.

Alpha Conversion Chart for EVS

A=*21	F=*33	K=*52	P=*71	U=*82	Z=*12
B=*22	G=*41	L=*53	Q=*11	V=*83	
C=*23	H=*42	M=*61	R=*72	W=*91	
D=*31	I=*43	N=*62	S=*73	X=*93	
E=*32	J=*51	O=*63	T=*81	Y=*93	

AVR/Speech Recognition

Providers without a touch-tone phone can access information using the AVR. The AVR system allows a caller to use a speech application. By speaking into the phone, a caller is able to use the system to get all the information they need. The system is available seven days a week from 5 am to 1 am.

Nationwide Toll Free: 800-767-3949

Oklahoma City Metro Area: 405-840-0650

SoonerCare Provider Portal Eligibility Verification

Providers have the ability to verify member eligibility through the SoonerCare Provider Portal.

Follow these steps to inquire on a member's eligibility.

1. Select the Eligibility tab.
2. Select the Eligibility Verification link.
3. Enter search criteria to verify eligibility. The field options are Member ID, Case Number, SSN, First and Last Name, Date of Birth, and Dates of Service.

Each option requires that a date-of-service (DOS) range of up to 13 months also be entered. The Calendar option to the right of each date field may be used for a fast selection of the date.

4. Click **Submit**.

Status A indicates the electronic request for eligibility was accepted by Oklahoma Medicaid and does not reflect the eligibility of the member. The eligibility and benefit programs for the member appear below the status.

5. Select a member ID from the search results to view eligibility details.
6. To print the eligibility results, click **Print Preview**. A new window displays, and you can print the eligibility details.

Follow these steps to add third-party liability (TPL) to a member's eligibility.

1. Follow steps 1-5 in the section 4.4, Eligibility Inquiry.
2. Click [+] to expand the TPL header.
3. Enter the name of the carrier in the Carrier Name field.
4. Enter the carrier ID in the Carrier ID field.
5. Enter the policy number in the Policy Number field.

6. Enter the group ID in the Group ID field.
7. Select the Person or Organization radio button from the Policy Holder field.
8. If you selected the Person radio button, enter the policy holder's first name, last name, and middle initial in the Policy Holder Last Name First Name and MI fields. If you selected the Organization radio button, enter the policy holder's organization in the Policy Holder Organization field.
9. Select the policy type from the Policy Type drop-down list.
10. Select the coverage type from the Coverage Type drop-down list.
11. Select the relationship from the Relationship drop-down list.
12. Enter the employer ID in the Employer ID field.
13. Enter the effective and end dates in the Effective and End Date fields.
14. Click **Add**.

Swipe Card

This device, similar to a credit card machine, hooks into a phone jack. The provider swipes the Medicaid SoonerCare ID card through the reader, which reads the magnetic strip. The eligibility information is displayed on the screen or printed on a paper slip. Providers interested in the swipe card option can contact a third party vendor for details.

Electronic Data Interchange (EDI)

EDI is a way for providers to check eligibility on a larger scale than the previous options. Providers purchase third party, HIPAA compliant software used to send a 270 transaction with their search criteria and receive a 271 response, which provides eligibility information. A 271 will give providers information on the different programs the member has as well as any TPL or Medicare information.



Chapter 5

Web



INTRODUCTION

The OHCA SoonerCare Provider Portal is one of the most exciting features of the Oklahoma Medicaid Management Information System (MMIS). Any SoonerCare provider can access the Web with a Provider ID and an OHCA-generated personal identification number (PIN). Once the provider has established a website account, the website administrator can create new clerks and grant each clerk role-specific access. The Web portal is free of charge and is available to any SoonerCare provider with internet access.

Important Web Site Notes

- Passwords are case sensitive
- All dates should be entered in MMDDYYYY format
- Dollars and cents should be separated by a decimal
- Line totals will not be calculated automatically; the user must multiply the units by the unit rate to ensure the correct total billed amount
- Do not populate the TPL amount unless another payer has paid a specific amount toward the claim
- Decimals should not be used when entering diagnosis codes

SECTION A: ACCESSING THE SOONERCARE PROVIDER PORTAL

The SoonerCare Provider Portal can be easily accessed on most computer systems with the following recommendations:

- Microsoft Internet Explorer browser version 7.0 and higher or Mozilla Firefox browser version 2.0 and higher, although other browsers may work.
- 128 bit encryption
- Customized security settings to access information across domains
- Disable pop-up ad blocker (or set settings to allow all for this website)

Getting to the SoonerCare Provider Portal

1. Navigate to www.okhca.org.

2. Select the Providers link at the top of the screen (see Screen Sample 5.1), and then select the Secure Sites link on the right.
3. On the OHCA Secure Web Site page, select the SoonerCare Secure Sites link.



Screen Sample 5.1

NOTE: *On the OHCA Web site, providers have complete access to all the latest Oklahoma Medicaid related information and updates.*

Log On Page

The Log On page serves as the access point for all Internet users. Users will initialize and create a website account log on from this page.

Account Initialization

Each new website account (users who have never registered with OHCA) will require initialization (creating a permanent username, password and challenge questions/answers—see Screen Sample 5.2). Existing users who have been registered with OHCA may log

into the new SoonerCare Provider Portal with their existing credentials.

oklahoma health care authority

Home

Contact Us | Login

Monday 12/16/2013 01:07 PM CST

Home

Login

*User ID

Log In

[Forgot User ID?](#)

[Register Now](#)

[Where do I enter my password?](#)

Broadcast Messages

To all Choice providers

You were notified of changes to your Choice contract in October. It involves mandatory integration of Behavioral Health Screenings into your medical home processes for member 5 and above. Please let us know if you did not receive this notification by e-mailing Provider Services Admins: ProviderServicesAdmins@okhca.org. We will send you another copy for your files.

Also be aware that Physician Assistants and Advance Nurse Practitioners who are Choice providers must have their DEA and OBND on file as part of the contracting approval process.

What can you do in the Provider Portal

Through this secure and easy to use internet portal, healthcare providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files containing 837 transactions, and search for another provider. In addition, healthcare providers can use this site to locate claim forms, provider participation materials and other health plan information and resources.

Helpful Links

- [Insure Oklahoma](#)
- [Child Health \(EPSDT\)](#)
- [Provider Enrollment](#)

[Website Requirements](#)

Screen Sample 5.2

Register Now

- Select Register Now from the Home page. Instructions for Registration Step 1 of 2 will vary by type:
 - Providers**—Enter the SC Provider Number, The Service Location and PIN in the respective fields.
 - Billing Agents**—Enter the Trading Partner ID and PIN in the respective fields.
 - Clerks**—Enter the First Name, Last Name, Birth Date, Last 4 of DLN, and Clerk Code in the respective fields (Clerk codes are generated by the provider).

Instructions for Registration Step 2 of 2-Security Information will be the same for all types:

- Enter a user ID. Select Check Availability to verify whether or not the user ID is available to use in the SoonerCare Provider

Portal. Enter a password in the Password and Confirm Password fields. Passwords must be 8-20 characters in length, contain a minimum of one numeric digit, one uppercase letter and one lowercase letter.

2. Enter a name in the Display Name field. This name will be the name that appears on the Provider main menu. Enter a phone number and extension, if applicable. Enter an email in the Email and Confirm Email fields.
3. Select a site key and enter a passphrase.
4. Select three questions from the Challenge Question #1-3 drop-down lists. Enter an answer in the respective Answer to #1-3 fields. For providers only, after reading the User Agreement, type in your name in the Please sign by typing your full name here field.
5. Once all fields have been entered, click **Submit**.

A confirmation message will be sent to the email on file, as entered in the Email field.

Types of Web Users

Providers

Providers will receive a letter by mail containing the provider's access PIN. This PIN, used in conjunction with the Provider ID, will grant the provider initial access to the SoonerCare Provider Portal. Only providers with an active SoonerCare contract will receive a PIN letter. Separate PIN letters will be mailed to each location. It is recommended that providers initialize their account and immediately create users (clerks) that will be used to operate the Internet application on a daily basis. Operating daily under the master user (Provider) poses certain security risks and should only be used when managing the account.

Billing Agents

Billing agents are given log-on credentials directly from HPES. When the users initialize their accounts, they will be prompted to establish a password, challenge questions and answers, site key token and contact information upon initializing their accounts.

Clerks

The provider or billing agent that created the clerk will give clerks log-on credentials. Users will be required to establish a password,

challenge questions and answers, site key token and contact information upon initializing their accounts.

Forgot Password

Users who forget their passwords may still gain access to the SoonerCare Provider Portal through the self-authentication process. The self-authentication process requires the user to change his or her password by selecting the Forgot Password? link from the Site Token Password page.

In the Forgot Password window, the user should answer the designated challenge question. Once the answer has been validated, a message will be sent to the email on record with a temporary password. Though not required, it is recommended that the user create a new password instead of using the temporary password.

SECTION B: WEB FEATURES

The OHCA SoonerCare Provider Portal has many features to help providers with everything related to Medicaid billing. This section will cover several OHCA secure site features.

Broadcast Messages

Broadcast messages will appear in top middle section of the home page after logging on. It will have messages from OHCA that can be directed to an individual provider, a specific provider type, or to the entire provider community.

After reading each message, select the Please acknowledge receipt of message by selecting this box check box. This will move the message to the mailbox for future reference until it expires.

After reading the messages, click **Next**.

Main Page

The Main page is also the user's home page. The Main page shows the User ID, the taxonomy number and contains shortcut links to areas of the Web site.

Switch Provider

The Switch Provider page is *only available to clerks and billing agents*. This feature allows the user to select the provider he or she wishes to access. The provider must add access to the billing agent

or other user by using Add Registered Clerk or Add Registered Billing Agent through Manage Accounts before this functionality is available. To switch to a different provider:

1. Select the Switch Provider tab from the main page.
2. Select the Switch Provider option from the menu.
3. Enter at least one criterion.
4. Click **Search**.
5. Select the radio button next to the provider from the Available Providers result list.
6. Click **Submit**.
7. Click **Close**.

Claims Page

The Claims page facilitates the communication of claim data between the OHCA and the provider community.

Providers without access to HIPAA compliant Practice Management software, a clearinghouse or a virtual access network (VAN) still have the ability to submit claims electronically. Direct data entry (DDE) enables the provider to submit individual claim information electronically to OHCA/HPES without the constraints of having to submit the data in HIPAA compliant format. DDE claim pages are available on the OHCA SoonerCare Provider Portal for claim types (i.e., professional, institutional, dental and pharmacy).

These pages contain separate box/fields where claim data must be populated. As with paper claim forms, box/field population requirements depend on the billing situation. However, if a provider attempts to submit a claim via the DDE page and has not populated all required fields, the system will prompt a pop-up box stating which required fields are unpopulated.

Direct Data Entry processes can only be performed one claim at a time.

Claim Inquiry

Users may inquire about claims already submitted to the OHCA/HPES using member ID, claim ID, status, dates of service and paid dates. A results box from the search will appear below the search criteria in the form of a summary list. Results will appear with navigation links below the box to view the next or previous list of results from the query. Each summary result item is linked to the claim detail page in the Claim ID field.

Performing a Claim Inquiry

1. Select Claims from the main menu to navigate to the Search Claims screen or move the mouse pointer over the Claims tab, highlight Search Claims, and then select it.
2. If known, the claim ID number can be entered in the Claim ID field. All other fields may be left blank.
3. If known, the member ID number can be entered in the Member ID field.
4. Enter a date in the Service From and To fields.
5. If known, the claim type can be selected from the Claim Type drop-down list.
6. The Claim Status field can be set to Denied, Paid, Suspended, or Resubmit.
7. If known, the claim paid date can be entered in the paid Date field.
8. Click **Search**.

From the search results, click [+] to expand the claim being viewed. Click the Claim ID to view detailed claim information. Select the Export results link to export claim results to an Excel spreadsheet.

Claim Submission

Providers need to confirm that they are logged in under the correct provider number location before starting claim submission.

<p><i>Institutional Claim Submission</i></p> <p>From this page, users may submit, resubmit, adjust and void institutional claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display in real time below the claim form in the claim status box.</p>	<p><i>Professional Claim Submission</i></p> <p>From this page users may submit, resubmit, adjust, and void professional claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display real time below the claim form in the claim status box.</p>
<p><i>Dental Claim Submission</i></p> <p>From this page, users may submit, resubmit, adjust and void dental claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display in real time below the claim form in the claim status box.</p>	<p><i>Pharmacy Claim Submission</i></p> <p>From this page, users may submit, rebill, and reverse pharmacy claims. Claims are sent as HIPAA compliant .xml format. The page includes field edits for data format and required fields. Claim adjudication response is immediate and EOBs display in real time below the claim form in the claim status box.</p>

Resubmit Claim-Denied Claims Only

1. Pull up Denied claims (from the Claim Status field), along with any other search criteria.
2. Select the Claim ID link of the claim that needs correction.
3. Click **Edit**.
4. Change the information in the field containing the incorrect data, and then click **Resubmit**.

Void Claim-Paid Claims Only

1. Pull up Paid claims (from the Claim Status field), along with any other search criteria.
2. Select the Claim ID link of the claim that needs to be voided.
3. Click **Void**. This will create an account receivable for the amount previously paid, which will be deducted from a future warrant. When available, the name of the person voiding the claim will appear when searching for a claim status.

Copy Claim-Paid Claims Only

1. Pull up Paid claims (from the Claim Status field), along with any other search criteria.

2. Select the Claim ID link of the claim that needs to be copied.
3. Click **Copy**.
4. Select the radio button that best fits the claim being submitted. Each radio button will display the fields that will be copied over to a new claim.
5. Click **Copy**.
6. After the new claim appears, make any additions to the new claim and submit.

Eligibility Page

The purpose of the Eligibility page is to verify eligibility of SoonerCare members. To run a query, a valid Member ID, Social Security Number, Birth Date, Name, or Case Number is required. These are combined with the From Date of Service and To Date of Service fields. The resulting data appears below the search criteria. Calendar buttons next to the dates of service fields will activate a calendar pop-up feature to aid date selection.

Pricing Page

The Search Fee Schedule page allows users to inquire on pricing information for procedures, drugs, and DRG through the Internet. Selecting the tabs for Procedure, NDC, or DRG will change the available options for searching. A drop-down list is available for the user to select the associated benefit package and the resulting data will be based on that selection. The search results summary will appear in a list below the criteria. This summary will be linked to a detail page.

Procedure Pricing

The detail page for procedure pricing will display the vital procedural components. The results link will only appear if data is located for the entered procedure code and other criteria. Displayed data may include:

- Allowed Amount
- Prior Authorization Required
- Age Restriction
- Maximum Units
- Gender
- Lifetime Limitation

- Dignosis Restrictions
- Specialty Restrictions
- Attachment Required
- Ambulatory Surgical Facility Fee
- Ambulatory Payment Classification Fee
- Discounted

NDC (Drug) Pricing

The detail page for drug pricing will display the vital data regarding the drug. The results link will only appear if data is located for the NDC code entered. Displayed data may include:

- State Maximum Allowable Cost (SMAC)
- Maximum Allowable Cost (MAC)
- Est. Acquisition Cost Wholesale (EACW)
- Est. Acquisition Cost Wholesale Percentage (EACW%)
- Est. Acquisition Cost Percentage (EAC%)
- Est. Acquisition Cost (EAC)
- Prior Authorization Required
- Maximum Units
- Maximum Days Supply
- Age Restrictions
- Gender Requirement
- Unit of Measure (Pharmacy Claims)
- Unit of Measure (Claims other than Pharmacy)

DRG Pricing

The detail results for DRG pricing is based on the DRG entered and the discharge date. The results will only appear if data is located for the DRG criteria entered. Displayed data may include:

- Peer Group
- Diagnosis Related Group (DRG)
- Rate

Prior Authorizations Page

The Prior Authorizations page allows the user to submit new PA requests, to inquire about pending prior authorization requests, and to inquire/copy notices.

Prior Authorization Submission

The Create Authorization link allows users to request a prior authorization.

The header section requests information about the patient and provider. Enter appropriate information in these fields. Below the header section is a Diagnosis summary box, which the user can add a primary diagnosis (the first diagnosis entered) and additional diagnosis codes. The Service Detail section is used to enter service type codes and related details. The Medical Justification box is used as a free-form text box for additional information from the provider to OHCA prior authorization analysts.

The next section consists of adding attachments. The user selects the method of transmission and uploads the file (if applicable), adds a description of the attachment, and then clicks **Add**. The user is instructed to add the attachment first, and then adds the service by selecting Add Service to associate the attachment to the service. When complete, users click **Submit**.

If required information is missing, the user will be prompted to enter that information, and then the user clicks **Submit** again.

An Attachment Form Cover Sheet will be generated for each attachment marked as By Mail or By Fax as the Transmission Method. The user will click **Attachment Coversheet(s)** at the Authorization Receipt screen to print the cover sheets.

Prior Authorization Inquiry

1. Select the Prior Authorizations link on the main menu.
2. Select the View Authorization Status link.
3. To view authorizations beginning with today's date or greater, select the Prospective Authorizations tab.
4. To search for authorizations using different criteria, select the Search Authorizations tab. If you have the PA number, enter it in the Authorization Tracking Number field.
5. If you don't have the PA number, you may search for it by entering the Member ID, Assignment Code, Code Type/Code, Day Range, or Service Date.
6. Click **Search**.

Search results are displayed in a list box. If additional results exist, they may be viewed by using the Pagination Numbers below the list box. Selecting the Authorization Tracking Number will open the PA detail window.

Search results may also be exported to an Excel spreadsheet by selecting the **Export results** link.

Prior Authorization Summary

The PA Summary page appears when a user searches a PA using the View Authorization Status page. The header section outlines information about the patient and provider. Below the header section is the Service Provider/Service Details Information section that displays the line items and notes.

To view additional authorization specific information, select [+] for each header listed.

Line item boxes are used to review procedure-code-related details and status. The Reason comments section relates to each line item highlighted in the Line Item summary box.

The Remarks column is used to review notes entered by an OHCA PA analyst. Select the View link to view comments.

- To view the original request sent, click **View Original Request**.
- To print a copy of the Summary, click **Print Preview**. A copy will appear in a new window and can be printed by clicking **Print**.
- To return to the Search Authorization tab, click **Back to View Authorization Status**.

Prior Authorization Notices

Go to the Prior Authorizations menu, select the View Authorization Status link, and then select the Authorization Notices tab and search by one of the following:

- Member ID or member name to access recent PA notices submitted under your provider number for that member.
- The Authorization tracking number of a specific PA. This brings up only the notices related to that number.
- Enter either a Day Range or From and To dates of service.
- Click **Search**, and you may view the PA notices under your provider number.

- Select the date listed under the Date Sent column. This brings up the PA notice letter, which can be printed.

On each column, providers can select the column links that allows them to sort in ascending or descending order.

Additional Tidbits for Successful Use

- When searching by either a specific PA number, member ID, or member name the Date Span fields are auto populated with a six-month span. The From date field counts back six months from the To date field. The To date field is the current day the research is being conducted.
- The Web program holds a 60-day rolling submission history. For example, if the PA request was entered into the system on 01/01/06, it will be available for online viewing until 03/02/06
- When logged on to a Group Provider number, the system will bring up PA information for every provider in that group

On the Authorization Notices menu, a message counter (Unread Notices) has been added that counts the number of unread PA notices under the provider log on.

Referrals

Create Referrals

The Create Referral tab under Referrals will allow the user to create a new referral. The Member Information will allow the user to enter the Recipient ID which will populate the member's name and birth date.

The Remaining Referral Information will allow the entry of the Referred To Provider by NPI. The user will then choose between Initial Visit Only and Ongoing Referral. The user will then enter the Referral Start Date and Referral End Date, and the Reason for Referral.

Referral Receipt

The Referral Receipt will show the Referral Tracking number as well as print options for the referral.

Search Referral

The Search Referral allows for providers to search for a referral by the following

- Referral Tracking number
- Recipient ID
- Referring or Servicing Provider.

Trade Files Page (BATCH SUBMISSION)

The Trade Files option is available to providers to facilitate file transfers between the provider community, billing agents, clearing houses, other involved agencies, and the OHCA.

File Upload

The File Upload page allows the user to select a file from a local hard drive and upload it to the OHCA. Users of this feature include providers that wish to upload batch claim submissions and managed care providers that wish to upload PCP information. Batch upload is an Internet submission option that is available to providers who wish to submit large claim batches or inquiries. To use the Batch Upload option, providers must use HIPAA compliant software or clearinghouse/VANs that can submit required data in HIPAA compliant ANSI X12 Addenda format. Once the provider has ensured the batch claim data have been converted into the corresponding HIPAA compliant format and have successfully completed authorization testing with the HPES-EDI team, they then have the ability to upload an entire batch file/transaction into the Oklahoma Medicaid Management Information System (OKMMIS).

If users wish to upload a batch, they must navigate to the Files Exchange menu. Pointing at the Files Exchange option, and then selecting the Upload Files link, which will also take the user to the upload page (see Screen Sample 5.3).

Screen Sample 5.3

From this page, the user will need to select the Transaction Type from the drop-down list. The user then clicks **Browse** to locate the file they wish to upload. At this point the user has the ability to change the file name in the Save as Filename box. Once the information is complete, the user clicks **Upload**.

When the file uploads, the user will receive an Upload File Confirmation pop-up window. This window will verify what the file was saved (see Screen Sample 5.4).

Screen Sample 5.4

The Upload process is now complete for the user. This process must be repeated for the files uploaded via the web.

To search for uploaded files, select the Search tab. Use the drop-down list to select the Transaction Type. Enter a partial filename in the Filename field. The results will display the Transaction ID and date the file was uploaded.

File Download

The File Download page allows the user to select a file from the provider secured Internet site and download it to their system. The

available files will be listed as file name links. The download process begins when the filename is selected. Users of this feature include providers that wish to download batch claims or response files, and managed care providers that wish to download managed care roster information.

To download a file (i.e., an 835 Remittance Advice), select the Download Files link. The Download page will open. The files that were created for the specific user/provider will be found on this page (Screen Sample 5.5).

oklahoma health care authority

My Home Eligibility Claims Care Management **Files Exchange** Resources LTC

Download Files | Upload Files

Contact Us | Logout
Friday 04/12/2013 05:54 PM EST

Files Exchange > Download Files

File Download ?

* Indicates a required field.
Enter your search criteria and click the **Search** button.

File Status

Category

*From Date *To Date

Search

Screen Sample 5.5

To download a file, select an option from the File Status drop-down list. Select a category type from the Category drop-down list. Enter a date range and click **Search**. A list of available files will appear. Select a file to start the download. (The file download will vary based on browser settings.)

NOTE: *If you are downloading multiple files, you will want to extract the file and rename it before downloading another file to avoid replacing the original file with your new file.*

Manage Accounts Page

The Manage Accounts page is designed to establish the security credentials for users and clerks, as well as allow users to update and maintain user account data.

Provider

After users access the Web site for the first time and initialize their account, they may access the Manage Accounts page. The provider

can delegate assignments by using the Add New Clerk, Add Registered Clerk, Add Registered Billing Agent, and Designate Billing Agent tabs.

Once the Provider has submitted the billing agent or clerk information, the billing agent or clerk can establish his or her user name, password, contact name, and email phone number by selecting the Register Now link in the general provider menu.

The status and authorized functions for billing agents and clerks are maintained by the provider using the Manage Accounts page.

Adding a New Clerk

Adding a clerk is done by selecting the Add New Clerk tab.

1. In the First and Last Name fields, enter the clerk's name.
2. In the Birth Date field, enter the clerk's birth date.
3. Enter the last four DLN of the clerk.
4. Select the check boxes of the functions the clerk will have authorization to access.
5. Click **Submit** once the information has been added.
6. Click **Confirm** to confirm the additions made to the new clerk.
7. Once the confirmation is complete an informational message will appear with a clerk code. The clerk code is used for the new clerk to register for the SoonerCare Provider Portal with the Register Now link. The clerk code can also be used if the existing clerk is registering under another provider.

Granting Access to Other Providers of Existing Billing Agent or Clerk

After a clerk or agent is created, he or she will automatically have access to the provider account under which he or she was created. For the clerk or agent to access other providers' accounts, access must be granted.

Add Registered Clerk

1. Select the Add Registered Clerk tab.
2. Enter the last name of the clerk.
3. Enter the existing clerk code generated by the previous provider.

4. Select the check boxes of the functions the clerk will have authorization to access.
5. Click **Submit** after adding the information.
6. Click **Confirm** to complete adding the registered clerk.

Add Registered Billing Agent

1. Select the Add Registered Billing Agent tab.
2. Enter the display name of the billing agent.
3. Enter the existing agent code. If the agent code is unknown, the agent code is located in My Profile-Role Qualifiers from the billing agent user account.
4. Select the check boxes of the functions the clerk or billing agent will have authorization to access.
5. Click **Submit** once the information has been added.
6. Click **Confirm** to confirm the additions made to the new clerk/billing agent

Revising Billing Agent or Clerk Access

When a billing agent or clerk no longer needs access to your provider account, or if functions need to be added/removed, you may edit account privileges.

1. From the Add New Clerk, Add Registered Clerk, or Add Registered Billing Agent tabs, a list of available users will appear at the bottom of each web page.
2. For clerks, select the name of the clerk to update access. For billing agents, select the billing agent code.
3. Edit the Status and/or the Functions of the clerk or billing agent.
4. Click **Submit** after adjustments have been made.
5. Click **Confirm** to confirm the changes.

Designate Billing Agent

The Designate Billing Agent function is used to allow billing agents to receive Capitation Summary, RA, and Roster transactions.

1. Select the Designate Billing Agent tab.
2. Select the transaction from the Transaction Type drop-down list.

3. Select the billing agent from the Billing Agent drop-down list.
4. Click **Designate to Receive**.

If all Transaction Types are designated to the billing agent, the Transaction Type drop down list will be disabled.

To remove a Transaction Type from a billing agent, select the Remove link associated with the transaction to be removed. Any transactions removed will then appear in the Transaction Type drop down list and can be added again at a later time.

Clerks and Billing Agents

Clerks and Billing Agents do not have the ability to create, grant access to, or revoke permissions of other users.

Broadcast Messages

The Broadcast Messages section contains messages from OHCA directed specifically to specific provider groups, such as specialties. Broadcast Messages will always display any active messages not checked as read. Next to each message is the following check box: Please acknowledge receipt of message by checking this box. When this is selected, the message will no longer appear at log on or once the page has been refreshed.

Help Page

The Help pages for the SoonerCare Provider Portal site are dynamic, meaning that the help text that displays is unique to the page that the user is viewing. Select the question mark [?] located at the right corner of each grey web page header. This will open an independent window giving details of the web page the user is currently navigating to.

Logout Page

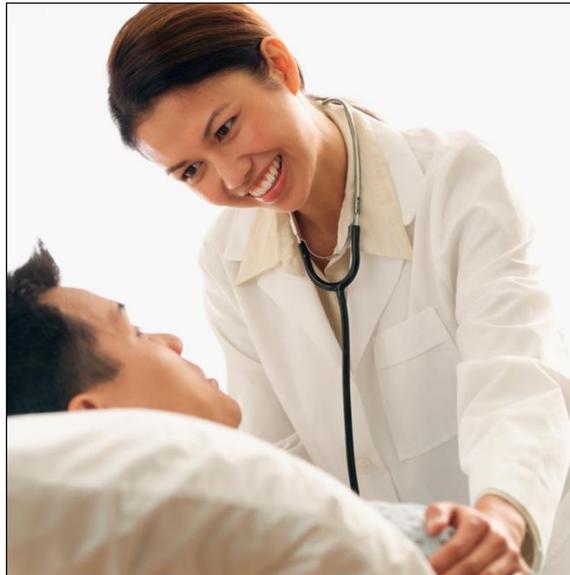
Selecting the Logout link ends the current session on the SoonerCare Provider Portal and redirects you to the non-secure menu options. Clicking **Login** will take the user to the Log On page.

This page intentionally left blank.



Chapter 6

Claim Completion



INTRODUCTION

The following information is intended to provide procedures for submitting claims to the OHCA. For information on what services are covered by the Oklahoma SoonerCare program, please access the agency rules. Rules can be found at www.okhca.org. There are three methods for submitting claims to the OHCA: paper, direct data entry (DDE) via the SoonerCare Provider Portal and through 837 batch transactions. Below is a paper-to-electronic conversion table for the different claim-submission types. Please refer to the EDI chapter of this manual for instructions on completing the HIPAA transaction types.

Paper	DDE	HIPAA Transactions
1500	Professional	837P
UB 04	Institutional	837I
ADA 2012	Dental	837D
Pharmacy Drug Claim Form	Pharmacy	NCPDP, version 5.1
Compound Prescription Drug Claim Form	Pharmacy	NCPDP, version 5.1

SECTION A: PAPER CLAIM RECOMMENDATIONS

Claim forms are prepared as follows:

1. Enter complete information with a typewriter, personal computer or ballpoint pen (blue or black ink). **Do not** use red ink.
2. Provide the required information for every claim line. **Do not** use ditto marks or the words “same as above.”
3. Verify the accuracy of the information before submitting the claim.
4. Follow the instructions for preparing paper claim forms in this chapter.
5. 1500, UB 04, Drug/Compound and ADA 2012 claim forms are scanned into the OKMMIS. Paper claim forms should be submitted on the original red forms to facilitate the scanning process. This applies to 1500 and UB 04 claim forms.

6. Mail paper claims to the appropriate mailbox address listed in each claim section.
7. The attachments for a claim should be placed under the identified claim for processing. Do not place the attachment on top of the claim form or it will be associated to previously processed claim. If the attachment is stapled to the claim, place one staple in the upper left corner.

Ordering Paper Claim Forms

UB-04, 1500, and ADA 2012 (dental) claim forms can be ordered from a standard form supply company. HPES does not distribute supplies of these forms. Drug and Compound prescription claim forms can be downloaded from the OHCA web site, ordered by contacting the OHCA Call Center or by writing a request to:

HPES Form Request

PO Box 18650

Oklahoma City, OK 73154-0650

SECTION B: 1500, PROFESSIONAL, 837P



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>																							
1. MEDICARE <input type="checkbox"/> (Medicare#)				MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK (LUNG) <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits from myself or to the party who accepts assignment below.) SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____ DATE _____											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL. _____						15. OTHER DATE MM DD YY QUAL. _____						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ind. _____ A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____												20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				23. PRIOR AUTHORIZATION NUMBER _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG _____		C. _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER _____		E. DIAGNOSIS POINTER _____		F. \$ CHARGES _____		G. DAYS OR UNITS _____		H. APPLIC. Family Plan _____		I. ID. QUAL. _____		J. RENDERING PROVIDER ID. # _____			
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO. _____				27. ACCEPT ASSIGNMENT? (For govt. programs, see 837P) YES <input type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$ _____				29. AMOUNT PAID \$ _____				30. Rsvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____						33. BILLING PROVIDER INFO & PH # () a. _____ b. _____											

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE OMB APPROVAL PENDING

FIELD DESCRIPTION FOR 1500 CLAIM FORM

The 1500 Health Insurance Claim Form (formerly known as the HCFA-1500 and CMS-1500), is the required claim form used by medical providers for professional services, unless otherwise specified. The provider must purchase these forms. This section explains how to complete the paper 1500 claim form.

The form locator chart below indicates which fields are *optional, required, required, if applicable or not captured*. Where necessary, directions applicable to specific provider types are noted. Please mail paper claims to the appropriate mailbox addresses below.

1500

HP Enterprise Services
P.O. Box 54740
Oklahoma City, OK 73154

Medicare Crossover (1500 Form)

HP Enterprise Services
P.O. Box 18110
Oklahoma City, OK 73154

Waiver Services

HP Enterprise Services
P.O. Box 54016
Oklahoma City, OK 73154

HMO Co-Pay/Personal Care Service (individual, not agency)

HP Enterprise Services
P.O. Box 18500
Oklahoma City, OK 73154

Lab or DME

HP Enterprise Services
P.O. Box 18430
Oklahoma City, OK 73154

Form Locator	1500 Field Description/Explanation
1	Insurance Location Selection – Enter X for Medicaid. <i>Required.</i>
1a	Insured’s ID Number – Enter the member’s SoonerCare identification number. Must be nine digits. <i>Required.</i>
2	Patient’s Name – (Last name, first name, middle initial) – Enter the member’s last name, first name and middle initial. <i>Required.</i>
3	Patient’s Birth Date – Enter the member’s birth date in MMDDYY format. Sex – Enter an X in the appropriate box. <i>Optional.</i>
4	Insured’s Name – (Last name, first name, middle initial). <i>Optional.</i>
5	Patient’s Address - (No., street), CITY, STATE, ZIP CODE, TELEPHONE (Include area code) – <i>Optional.</i>
6	Patient relationship to insured – <i>Optional.</i>
7	Insured’s Address - (No., street), CITY, STATE, ZIP CODE, TELEPHONE (Include area code) – <i>Optional.</i>
8	Patient Status – Enter X in the appropriate box. <i>Optional.</i>
9	Other Insured’s Name – <i>Optional.</i>
9a	Other Insured’s Policy or Group Number – <i>Optional.</i>
9b	Other Insured’s Date of Birth. Enter the date in MMDDYY format. – <i>Optional.</i> Sex – Enter X in the appropriate box. <i>Optional.</i>
9c	Employer’s Name or School Name – <i>Optional.</i>
9d	Insurance Plan Name or Program Name – If other insurance is available, enter the commercial or private insurance plan name. <i>Required, if applicable.</i>
10	Is Patient’s Condition Related to – Enter X in the appropriate box of each of the three categories. This information is needed to follow-up third party recovery actions. <i>Required, if applicable.</i>
10a	Employment? – (Current or previous) – Check “Yes” or “No” to indicate if the services being billed are employment related. <i>Required, if applicable.</i>
10b	Auto Accident? – Check “Yes” or “No” to indicate if the services being billed are related to an auto accident. <i>Required, if applicable.</i> Place (State) – Enter the two-character state code. <i>Required, if applicable.</i>
10c	Other Accident? – Check “Yes” or “No” to indicate if services being billed are related to an accident of another type. <i>Required, if applicable.</i>

Form Locator	1500 Field Description/Explanation
10d	Not Captured.
11	Insured's Policy Group or FECA Number – If the member has more than one private or commercial insurance, follow directions for form locator 9 in this area. <i>Required, if applicable.</i>
11a	Insured's Date of Birth. - <i>Optional.</i>
11b	Employer's Name or School Name – <i>Optional.</i>
11c	Insurance Plan Name or Program Name – If other insurance is available, enter the commercial or private insurance plan name. <i>Required, if applicable.</i>
11d	Is There Another Health Benefit Plan – Enter X in the appropriate box. Provide additional third, or more private or commercial insurance information on a separate piece of paper using the directions found in form locator 9. <i>Required, if applicable.</i>
12	Patient's or Authorized Person's Signature. – <i>Optional.</i>
13	Insured's or Authorized Person's Signature – <i>Optional.</i>
14	Date of Current Injury, Illness, or Pregnancy – Enter the date in a MMDDYY format of the onset of the illness (day of first symptom) or injury (accident). OB claims must indicate the date the member was first seen for the pregnancy. <i>Required, if applicable, or if form locator 10 has a box checked 'Yes'.</i>
14 Qualifier	Enter applicable qualifier: 431 – Onset of Current Symptoms or Illness 481 – Last Menstrual Period
15	If Patient Has Had Same or Similar Illness, Give First Date – Enter date in MMDDYY format. <i>Optional.</i>
15 Qualifier	If Patient Has Had Same or Similar Illness, Give First Date – Enter date in MMDDYY format. <i>Optional.</i> Enter applicable qualifier: 454 – Initial Treatment 304 – Latest Visit or Consultation 453 – Acute Manifestation of a Chronic Condition 439 – Accident 455 - Last X-ray 471- Prescription 090 – Report Start 091 – Report End 444 – Report EndrtstaConsultation
16	Date Patient Unable to Work in Current Occupation. – <i>Optional.</i>

Form Locator	1500 Field Description/Explanation
17*	Enter the qualifier “DN” for the Referring Provider or “DK” for the Ordering Provider in the first small box. <i>Required, if applicable.</i>
17a (shaded area)	ID Number of Referring Physician – (small box) Enter the two-character qualifier “1D” to indicate the referring provider’s ID number is a SoonerCare ID number. <i>Optional.</i> (large box) Enter the 10-character referral number from the Referral Form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. Referral form submission with the claim is not required. <i>Required, if applicable.</i>
17b (unshaded area)	NPI Number of Ordering or Referring Physician – Enter the 10-digit National Provider Identifier (NPI) number of the ordering physician or the 10-digit (NPI) number from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. Referral form submission with the claim is not required. <i>Required, if applicable.</i>
18	Hospitalization Dates Related to Current Service – Enter the requested FROM and TO dates in MMDDYY format. <i>Required, if applicable.</i>
19	If the primary insurance carrier did not issue payment, write the words, “Carrier Denied” in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims. <i>Required, if applicable.</i>
20	Outside Lab– Enter X in the appropriate box. Optional \$ CHARGE – Eight-digit numeric field. <i>Optional.</i>
21.A to 21.L	Diagnosis Nature of Illness or Injury – Enter up to 12 ICD diagnosis codes, with up to 7 characters per code, in order of importance. These indicators will correspond to the appropriate procedures and be listed in box 24E. <i>Required, if applicable.</i>
22	SoonerCare Resubmission Code, Original Ref No. – <i>Optional.</i>
23	Prior Authorization Number – The prior authorization (PA) number is not required as the information is systematically verified. <i>Optional.</i> The CLIA certification number is required to be put in this block when billing for laboratory services. <i>Required, if applicable.</i>

Form Locator	1500 Field Description/Explanation
24 a – j (shaded area)	<p><i>24a</i> – Enter NDC qualifier “N4” followed by the 11-digit NDC number in 24a. (e.g. N49999999999) N4 should go directly over dates. Do not enter any spaces or dashes.</p> <p><i>24b and 24c</i> – Do not enter any information in these fields.</p> <p><i>24d</i> – Enter the unit of measure of “UN” for unit, “F2” for international unit, “ML” for milliliter or “GR” for gram followed by the metric decimal quantity. For example: UN103.50. Do not use spaces or dashes and do not include a description or any information beyond what is indicated above. The NDC should be placed in shaded area above the corresponding HCPCS codes (refer to 24d unshaded area for additional instructions).</p> <p><i>24e through 24g</i> – Do not enter any information in these fields.</p> <p><i>24h</i> – Enter a “Y” or “N”, if applicable.</p> <p><i>24i</i> – Required two-digit character. (e.g. 1D)</p> <p><i>24j</i> – Enter the nine-digit, one alpha character SoonerCare legacy rendering number in 24j. (e.g. 100234567A)</p>
24 (unshaded area)	Detail service lines should be listed in the unshaded areas of 24a - 24j. A maximum of six service lines are allowed per claim.
24a (unshaded area)	Date of Service – Enter FROM and TO dates in MMDDYY format for the billing period for each service rendered. Six detail lines are allowed per form. <i>Required.</i>

Form Locator	1500 Field Description/Explanation																																																												
24b (unshaded area)	Place of service – Enter the place of service code for the place services were rendered. <i>Required.</i> <table border="1" data-bbox="716 338 1406 1696"> <thead> <tr> <th colspan="2" data-bbox="716 338 1406 373">Place of Service Codes</th> </tr> <tr> <th data-bbox="716 373 834 415">Code</th> <th data-bbox="834 373 1406 415">Description</th> </tr> </thead> <tbody> <tr><td>11</td><td>Office</td></tr> <tr><td>12</td><td>Home</td></tr> <tr><td>20</td><td>Urgent care facility</td></tr> <tr><td>21</td><td>Inpatient hospital</td></tr> <tr><td>22</td><td>Outpatient hospital</td></tr> <tr><td>23</td><td>Emergency room</td></tr> <tr><td>24</td><td>Ambulatory surgical center (ASC)</td></tr> <tr><td>25</td><td>Birth center</td></tr> <tr><td>26</td><td>Military treatment facility</td></tr> <tr><td>31</td><td>Skilled nursing facility (SNF)</td></tr> <tr><td>32</td><td>Nursing facility (NF)</td></tr> <tr><td>33</td><td>Custodial care facility</td></tr> <tr><td>34</td><td>Hospice</td></tr> <tr><td>41</td><td>Ambulance – land</td></tr> <tr><td>42</td><td>Ambulance – air or water</td></tr> <tr><td>51</td><td>Inpatient psychiatric facility</td></tr> <tr><td>52</td><td>Psychiatric facility – partial hospitalization</td></tr> <tr><td>53</td><td>Community mental health center</td></tr> <tr><td>54</td><td>Intermediate care facility for the mentally retarded (ICF/MR)</td></tr> <tr><td>55</td><td>Residential substance abuse treatment facility</td></tr> <tr><td>56</td><td>Psychiatric residential treatment center</td></tr> <tr><td>61</td><td>Comprehensive inpatient rehabilitation facility</td></tr> <tr><td>62</td><td>Comprehensive outpatient rehabilitation facility</td></tr> <tr><td>65</td><td>End-stage renal disease treatment facility</td></tr> <tr><td>71</td><td>State or local public health clinic</td></tr> <tr><td>72</td><td>Rural health clinic (RHC)</td></tr> <tr><td>81</td><td>Independent laboratory</td></tr> <tr><td>99</td><td>Other unlisted facility</td></tr> </tbody> </table>	Place of Service Codes		Code	Description	11	Office	12	Home	20	Urgent care facility	21	Inpatient hospital	22	Outpatient hospital	23	Emergency room	24	Ambulatory surgical center (ASC)	25	Birth center	26	Military treatment facility	31	Skilled nursing facility (SNF)	32	Nursing facility (NF)	33	Custodial care facility	34	Hospice	41	Ambulance – land	42	Ambulance – air or water	51	Inpatient psychiatric facility	52	Psychiatric facility – partial hospitalization	53	Community mental health center	54	Intermediate care facility for the mentally retarded (ICF/MR)	55	Residential substance abuse treatment facility	56	Psychiatric residential treatment center	61	Comprehensive inpatient rehabilitation facility	62	Comprehensive outpatient rehabilitation facility	65	End-stage renal disease treatment facility	71	State or local public health clinic	72	Rural health clinic (RHC)	81	Independent laboratory	99	Other unlisted facility
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24c (unshaded area)	EMG - Emergency indicator. If services are related to an emergency, enter 'Y'. If not, enter 'N'. <i>Optional.</i>																																																												

Form Locator	1500 Field Description/Explanation				
24d (unshaded area)	<p>Procedures, Services, or Supplies CPT/HCPCS – Enter the appropriate procedure code for the service rendered. Only one procedure code is billed on each claim form detail line. If your procedure code requires an NDC, enter the appropriate HCPCS code and refer to 24 a-j shaded area for additional instructions. <i>Required.</i></p> <p>Modifier – Enter the appropriate modifier, as applicable. Up to four modifiers can be entered for each detail line. <i>Required, if applicable.</i></p>				
24e (unshaded area)	<p>Diagnosis Pointer – Enter the alpha codes (A-L), in order of importance, which correspond to the ICD diagnosis code listed in form locator 21. A minimum of one and maximum of four diagnosis code pointers can be entered on each line. Do not enter the full diagnosis code. <i>Required, if applicable.</i></p>				
24f (unshaded area)	<p>\$ Charges – Enter the charges for each line item on the claim form. <i>Required.</i></p>				
24g (unshaded area)	<p>Days or Units – Enter the appropriate number of units of services provided for the procedure code. Whole and decimal numbers are acceptable. <i>Required.</i></p>				
24h (unshaded area)	<p>EPSDT Family Plan – If the services being provided are related to an EPSDT visit, enter ‘Y’. If not, enter ‘N’ or leave blank. If a ‘Y’ is entered, the two-digit EPSDT code must be entered in the shaded area above the box. <i>Required, if applicable.</i></p>				
24h (shaded area)	<p>EPSDT Family Plan – If a ‘Y’ is entered in the unshaded area of box 24h, enter the two-digit referral type in this box. Appropriate codes are:</p> <table border="1" data-bbox="706 1377 1409 1528"> <tbody> <tr> <td data-bbox="706 1377 1052 1451">NU – Not Available</td> <td data-bbox="1052 1377 1409 1451">AV – Available, Not Used</td> </tr> <tr> <td data-bbox="706 1451 1052 1528">ST – New Services Requested</td> <td data-bbox="1052 1451 1409 1528">S2 – Under Treatment</td> </tr> </tbody> </table>	NU – Not Available	AV – Available, Not Used	ST – New Services Requested	S2 – Under Treatment
NU – Not Available	AV – Available, Not Used				
ST – New Services Requested	S2 – Under Treatment				
24i – 24j	<p>When entering the rendering provider’s ID number, only use the shaded areas of 24i – 24j. When entering the Providers NPI number, use the unshaded area of 24j.</p>				
24i (shaded area)	<p>ID Qual. – Enter the two-character qualifier, indicating the type of provider number being used for the rendering provider. Enter ‘1D’ to indicate the type of provider number used is for Oklahoma SoonerCare. <i>Optional.</i></p>				

Form Locator	1500 Field Description/Explanation
24j (shaded area)	Rendering Provider ID # - Enter the 10-character Oklahoma SoonerCare provider number of the rendering provider. This field can be left blank if billing and rendering numbers, including location code, are identical. <i>Required, if applicable.</i>
24i (unshaded area)	ID Qual – This area is already populated with ‘NPI,’ indicating that the provider number listed for the rendering provider is the NPI.
24j (unshaded area)	Rendering Provider ID # - Enter the rendering provider’s 10-digit NPI. <i>Optional.</i>
25	Federal Tax ID Number – <i>Optional.</i>
26	Patient’s Account Number – Enter the internal patient tracking number. If the account number is supplied, it will appear on the remittance advice. <i>Optional.</i>
27	Accept Assignment? – Oklahoma SoonerCare only accepts assigned claims. <i>Required.</i>
28	Total Charges– Enter the total of column 24f charges. Each page must have a total. Claims cannot be continued to two or more pages. <i>Required.</i>
29	Enter the total dollar amount paid by a primary insurance carrier (for example, 45.00). You do not need to enter a dollar sign (\$). Do not put amount paid by Medicare. <i>Required, if applicable.</i>
30	Not captured.
31	Signature of Physician or Supplier– The name of the authorized person, someone designated by the agency or organization and the date the claim was created. A signature stamp is acceptable; however, the statement “Signature on File” is not allowed. <i>Required.</i> DATE – Enter the date the claim was filed. Be sure not to write any portion of the date outside of the designated box. The date billed must be on or after the date(s) of service. <i>Required.</i>
32	Name and Address of Facility Where Services Were Rendered - Enter the provider’s name and address if other than home office. <i>Optional.</i>
32a	Enter the 10-digit NPI number of the facility where the services were rendered. <i>Optional.</i>
32b	Enter the two-character qualifier “1D” and 10-character Oklahoma SoonerCare provider ID number of the facility where the services were rendered. No spaces or dashes should be used. <i>Optional.</i>

Form Locator	1500 Field Description/Explanation
33	PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE # - Enter the name, address, zip code and telephone number of provider requesting payment for services listed on claim form. If the provider furnished the services as part of a group practice organization, enter the name, address, zip code and telephone number of the group practice organization. <i>Required.</i>
33a	Enter the 10-digit NPI number of the physician or group. <i>Optional.</i>
33b	Enter the 10-character Oklahoma SoonerCare provider ID number of the billing provider. No spaces or dashes should be used. <i>Required. (Use of the 1D Medicaid qualifier is optional)</i>

Direct Data Entry (DDE) Claim Submission – Professional

Use the Professional claim form example and directions below as guides when submitting claims through DDE on the SoonerCare Provider Portal. Choose the Submit Claim Prof (see Screen Sample 6.1) claim option from the Claims menu to open the form (Screen Sample 6.2).



Screen Sample 6.1

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type Professional

Provider Information

General Provider Header Instructions

Billing Provider ID	ID Type NPI	Name
Zip Code 74006-2495	Taxonomy	SC Provider Number
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>	
Ordering Provider ID <input type="text"/>	ID Type <input type="text"/>	Ordering Zip Code <input type="text"/>

Patient Information

General Patient Instructions

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Claim Header Instructions

Date Type <input type="text"/>	Date of Current <input type="text"/>
Accident Related <input type="text"/>	Expected Delivery Date <input type="text"/>
Patient Account Number <input type="text"/>	To Date <input type="text"/>
From Date <input type="text"/>	
CLIA Number <input type="text"/>	
*Other Insurance Include <input type="text"/>	

Total Charged Amount \$0.00

Continue **Cancel**

Diagnosis Codes -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			
1	*ICD Version ICD-9-CM	*Diagnosis Code <input type="text"/>	

Add **Reset**

Other Insurance Details -

TPL Amount

Back to Step 1 **Continue** **Cancel**

Screen Sample 6.2

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

*Charge Amount *Units 1.00 Unit Type Unit EPSDT

CLIA Number

Rendering Provider ID ID Type Zip Code Contract Code

Taxonomy

NDC for Item 1

If applicable, only one NDC/UPN is allowed per service detail line. When adding an NDC/UPN, the Code Type, Quantity and Unit of Measure fields are required.

Code Type NDC

NDC/UPN

Quantity Unit of Measure

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
	*Transmission Method FT-File Transfer	*Upload File <input type="text"/>		*Attachment Type <input type="text"/>	

Click to collapse.

*Upload File

*Attachment Type

Description

Screen Sample 6.2 continued

Claim Type

- Professional
- Professional
- Crossover Professional

Above the Provider Information heading select the Claim Type drop-down list and choose Crossover Professional. The Crossover Details section should now be visible (Screen Sample 6.3).

Medicare Crossover Details	
Medicare Crossover Instructions	
Allowed Medicare Amount	<input type="text"/>
Deductible Amount	<input type="text"/>
Medicare Payment Amount	<input type="text"/>
Co-insurance Amount	<input type="text"/>
Psychiatric Services Amount	<input type="text"/>
*Medicare Payment Date	<input type="text"/> 

Screen Sample 6.3

Under the Medicare Crossover Details heading enter the Medicare allowed amount in the **Allowed Medicare Amount** field.

DDE PROFESSIONAL CLAIM SUBMISSION INSTRUCTIONS
Provider Information
Billing Provider ID – Provider Number – Your Provider ID and provider information should auto-populate. Verify that it is correct. If it is not, you may need to log out and access the correct provider. <i>Required</i>
Referring Provider ID – Enter the 10-character referral number from the referral form, if the member is enrolled in the SoonerCare Choice program. See 1500 form locator 17A. <i>Required, if applicable</i>
Ordering Provider ID – Enter the ordering provider ID. <i>Required if applicable</i>
ID Type – Select the applicable ID type from the drop-down list.
Ordering Zip Code – Enter the Zip code.
Patient Information
Member ID – Enter the member’s Oklahoma SoonerCare ID number in the Client ID field. (The patient’s last and first name along with birth date will auto-populate when the member’s ID number is in the system). <i>Required</i>
Claim Information
Date Type – Select the applicable date type from the drop-down list. <i>Required if applicable</i>
Date of Current – Enter the date of current status from the date type selected. <i>Required, if applicable</i>
Accident Related – Select the applicable option to describe the accident.
Admission Date – Enter the date of admission.

DDE PROFESSIONAL CLAIM SUBMISSION INSTRUCTIONS
Patient Account # – The patient account number will be captured and appear on the remittance advice, if entered into this field. <i>Optional</i>
Expected Delivery Date – If the claim is related to pregnancy, enter the expected delivery date.
From Date – This field will auto-populate.
To Date – This field will auto-populate.
CLIA Number – Required when billing for laboratory services. <i>Required, if applicable</i>
Other Insurance – Select the applicable option for other insurance.
Total Charged Amount – The Total Charges field is automatically populated.
Medicare Crossover Details (when Crossover Professional is selected)
Allowed Medicare Amount – Enter the allowed Medicare amount.
Co-insurance Amount – Enter the co-insurance amount.
Deductible Amount – Enter the deductible amount.
Psychiatric Services Amount – Enter the psychiatric services amount.
Medicare Payment Amount – Enter the Medicare payment amount.
Medicare Payment Date – Enter the payment date (<i>required</i>).
Diagnosis Codes
ICD Version – Use the drop-down list to select a diagnosis type. <i>Required</i>
Diagnosis Code – Enter at least three characters to begin searching for a diagnosis code. <i>Required</i>
Other Insurance Details (When Other Insurance-Include) is selected)
TPL Amount – Enter the TPL amount.
Service Information
From Date – Enter the beginning date of service in the From Date field. <i>Required</i>
To Date – Enter the end date of service in the To Date field.
Place of Service – Select the place of service code using the drop-down list. <i>Required</i>

DDE PROFESSIONAL CLAIM SUBMISSION INSTRUCTIONS
EMG – If claim is related to an emergency, select from the drop-down list. <i>Required, if applicable</i>
Procedure Code – Enter the CPT or HCPCS procedure code in the Procedure field. See 1500 form locator 24d for more information. <i>Required</i>
Modifiers – Enter modifier code(s) in the Modifier field(s). <i>Required, if applicable</i>
Diagnosis Pointers – Use the drop-down lists to select the numeric codes (1, 2, 3 or 4), in order of importance, which correspond to the ICD diagnosis code listed in form locator 21. A minimum of one and maximum of four diagnosis code pointers can be entered on each line. <i>Required</i>
Charge Amount – Enter the total dollar amount of charges for that specific detail in the Charges field (<i>required</i>). If units are greater than one, multiply the number of units by the amount billed per unit. This action will auto-populate the Total Charges field.
Units – Enter number of units billed in the Units field. <i>Required</i>
Unit Type – Please ignore, this field is auto populated by default.
EPSDT – If claim is related to an EPSDT service, select the appropriate referral type from the drop-down list. If nothing is entered, this field will default to No. <i>Required, if applicable</i>
CLIA Number – Enter the CLIA number.
Rendering Provider ID – If different from the billing provider number, enter the rendering physician’s NPI number in the Rendering NPI field. This is the rendering provider and is not necessarily a physician. <i>Required, if applicable</i>
ID Type – Select from the drop-down list to determine the ID type.
Zip Code – Enter the rendering provider’s Zip code +4, if applicable.
Contract Code – Select from the drop-down list, if applicable.
Taxonomy – Enter the rendering provider’s taxonomy, if applicable.
SC Provider Number – Enter the SC provider number.
NDC for Item #

DDE PROFESSIONAL CLAIM SUBMISSION INSTRUCTIONS
Code Type – Please ignore, this field is auto populated by default.
NDC/UPN – Enter the NDC or UPN code in the Procedure field.
Quantity – Enter the quantity.
Unit of Measure – Select the drop-down list to determine the type of measurement.
Attachments
Transmission Method-Select the drop-down list to determine how attachments will be sent. <i>Required, if applicable</i>
Upload File – Click Browse to locate file being uploaded; available when selecting FT-File Transfer. <i>Required, if applicable</i>
Attachment Type – Select the drop-down list to determine the type of file. <i>Required, if applicable</i>
Description – Enter a description of the attachment.
If a hard-copy attachment is to be added, a system generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list. (See Section F in this chapter for instructions on sending form HCA-13 by fax or mail.)
Unique attachment control numbers (Control #) are generated once an attachment is added; <i>Required, if applicable</i>
Submit - When finished, click Submit . <i>Required</i>

Field Descriptions For The UB-04 Claim Form

The **UB-04** Universal Billing Claim Form, is used to bill for facility services covered under the OHCA's Medical Program, unless otherwise specified in this chapter. The provider must purchase these forms. This section explains how to complete the paper UB-04 claim form. The form locator chart indicates which fields are optional; required; required, if applicable or not captured.

Providers should use the UB-04 billing manual instructions unless otherwise specified. The UB-04 manual can be obtained by contacting the National Uniform Billing Committee at www.nubc.org. Please mail paper claims to the appropriate mailbox address below:

UB-04 (Hospital or Home Health)

HP Enterprise Services
P.O. Box 18430
Oklahoma City, OK 73154

HMO Co-pay

HP Enterprise Services
P.O. Box 18500
Oklahoma City, OK 73154

Long-term-care Nursing Facility

HP Enterprise Services
P.O. Box 54200
Oklahoma City, OK 73154

Medicare Crossovers (UB-04)

HP Enterprise Services
P.O. Box 18110
Oklahoma City, OK 73154

Form Locator	UB-04 Field Description/Explanation
1	Please Remit Payment To – Provider name, address and telephone number. <i>Required</i>
2	Unlabeled field <i>Not captured</i>
3a	PATIENT CNTL #. – Enter the internal patient account number. This number will appear on the remittance advice. Up to 24 characters. <i>Required</i>

Form Locator	UB-04 Field Description/Explanation
3b	MED REC # - This is a HIPAA required number that must be no more than 24 characters. This number is assigned by the provider to identify the medical health records of the patient. <i>Required</i>
4	TYPE OF BILL – Enter the code indicating the specific type of bill. This four-digit code requires one digit from each of the following categories, including a leading zero. First - leading 0 (optional); Second – Type of Facility; Third – Bill Classification; Forth - Frequency Please consult the National UB-04 Uniform Billing Manual for type of bill codes. <i>Required</i>
5	FED. TAX NO. <i>Not captured</i>
6	STATEMENT COVERS PERIOD – Enter the beginning and ending service dates included in this bill (<i>required</i>). For all services rendered on a single day, use both the FROM and THROUGH dates. Enter in the MMDDYY format, such as 011205. Total days must equal days shown indicated in form locator 39-41 and total units located in form locator 46 with the exception of discharge day. <i>Required</i>
7	Unlabeled field <i>Not captured</i>
8 a-b	PATIENT NAME – a - Not captured. b – Enter member’s last name, first name, and middle initial. <i>Required</i>
9 a-e	PATIENT ADDRESS <i>Not captured</i>
10	BIRTHDATE <i>Not captured</i>
11	SEX <i>Not captured</i>
12	ADMISSION DATE – Enter the date the patient was admitted for inpatient care in a MMDDYY format. <i>Required.</i>

Form Locator	UB-04 Field Description/Explanation
13	ADMISSION HOUR – Enter the two-digit code for the hour during which the patient was admitted for inpatient care using the 24 hour format (for example: 7:00 PM = 19). <i>Required</i>
14	ADMISSION TYPE – Enter the code indicating the priority of this admission. Type must be numeric. See NUBC’s UB-04 manual for details. <i>Required</i>
15	SOURCE OF ADMISSION– Enter code indicating how the patient was admitted. See NUBC’s UB-04 manual for more detail. <i>Required</i>
16	DHR <i>Not captured</i>
17	STAT – Enter the code indicating the member status as of the ending service date of the period covered on this bill. This is a two-digit 01-99 code. Codes for patient status are detailed in the National UB-04 Uniform Billing Manual and indicate if the member is still a patient, deceased, discharged and other statuses. See NUBC’s UB-04 manual for more detail. <i>Required</i>
18 - 28	CONDITION CODES – Enter appropriate code. See NUBC’s UB-04 manual for more detail. <i>Optional</i>
29	ACDT STATE <i>Not captured</i>
30	Referring Provider ID Number – Enter the 10-character referral number from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma programs (for example, 123456789A). Referral form submission with the claim is not required. <i>Required, if applicable</i>
31-34 a & b	OCCURRENCE CODE and DATE – Enter the applicable code and associated date to identify significant events related to this bill that may affect processing. Dates are entered in a MMDDYY format. A maximum of eight codes and associated dates can be entered. See NUBC’s UB-04 manual for more detail. <i>Required, if applicable.</i>

Form Locator	UB-04 Field Description/Explanation
35-36 a – b	OCCURRENCE SPAN CODE, FROM/THROUGH – Enter the code and associated dates for significant events related to this bill. Each Occurrence Span Code must be accompanied by the span from and through date. <i>Required, if applicable</i>
37b-c	Unlabeled field <i>Not captured</i>
38	Unlabeled field <i>Not captured</i>
39a – 41d	VALUE CODES –Enter code and amounts as applicable. Value Code 80 specifies the number of covered days. Days need to be listed in whole numbers, no decimals. <i>Required, if applicable</i>
42 Lines 1- 22	REVENUE CODES – Enter the applicable revenue code that identifies the specific accommodation, ancillary service, or billing calculation. The use of revenue code 001 is not required to indicate total billed; if programmed please put 001 in form locator 42 line 23. <i>Required</i>
43 Lines 1- 22	DESCRIPTION – Using no spaces or dashes, enter NDC qualifier “N4;” the 11-digit NDC number; the unit of measure of “UN” for unit, “F2” for international unit, “ML” for milliliter or “GR” for gram; and the metric decimal quantity. For example: N49999999999UN999.99. Corresponding HCPCS code should be placed on the same line as NDC. <i>Required, if applicable</i>
44 Lines 1- 22	HCPCS/RATES – Enter the Health Care Procedure Coding System (HCPCS) code applicable to the service provided. Only one service code per line is permitted. <i>Required for DME, outpatient, X-ray, lab, rural health, EKG, EEG, and pharmacy.</i>
45 Lines 1- 22	SERVICE DATE – The date the indicated outpatient service was provided on a series bill. <i>Required for all services except inpatient and long term care.</i>
46 Line 1- 22	UNITS OF SERVICE – Enter the number of units corresponding to the revenue code and/or HCPCS code billed. <i>Required</i>

Form Locator	UB-04 Field Description/Explanation
47 Lines 1-22	TOTAL CHARGES – Enter the total charges pertaining to the related revenue code detail line. On the detail line that has the revenue code 001, add all of the charge details together and enter the sum of all charges billed in form locator 47. <i>Required</i>
48	NON-COVERED CHARGES <i>Not captured</i>
49	Unlabeled Field <i>Not captured</i>
42 Line 23	Unlabeled. Enter the revenue code 001. <i>Optional</i>
43 Line 23	Page ___ of ___. The OHCA does not accept multiple-page claims. <i>Not used</i>
45 Line 23	CREATION DATE - Enter the date billed. <i>Required.</i>
47 Line 23	TOTAL - Enter the total charges adding lines 1-22 together. <i>Required</i>
48 Line 23	Unlabeled: Total non-covered charges from lines 1-22. <i>Not captured</i>
50A-55C	For form locators 50a-55c –Enter the appropriate order of insurance coverage A, Primary; B, Secondary; and C, Tertiary; for example, A, Medicare; B, Medicare Supplement; and C, SoonerCare. If the member only has SoonerCare coverage, it should be listed in A. <i>Required</i>
51A – 51C	HEALTH PLAN ID <i>Not captured</i>
52A-C	REL INFO <i>Not captured</i>
53a – 53c	ASG. BEN. <i>Not captured</i>
54A – 54C	PRIOR PAYMENTS - Enter the amount paid by the insurance carrier identified in form locators 50a-b, as applicable. <i>Required, if TPL applies</i> <div style="border: 1px solid black; padding: 5px;"><i>When a TPL carrier makes payment on a claim, the Explanation of Benefits (EOB) is not required. The Explanation of Benefits (EOB) is always required if the TPL carrier denies the claim.</i></div>

Form Locator	UB-04 Field Description/Explanation
55a – 55c	EST. AMOUNT DUE – The amount estimated by the provider to be due from the indicated payer. (estimated responsibility less prior payments). <i>Used for HMO Co-pays only</i>
56	NPI –Enter the NPI of the billing provider. <i>Optional</i>
57 a-c	Enter the 10-character SoonerCare provider ID for the billing provider in the corresponding line a – c from form locator 50 that indicates SoonerCare or Medicaid. <i>Required</i>
58A – 58C	INSURED’S NAME – Enter insured’s last name, first name, and middle initial. <i>Not captured</i>
59A – 59C	P. REL – Patient’s relationship to insured. <i>Not captured</i>
60A – 60C	INSURED’S UNIQUE ID. – Enter the member’s identification number for the respective payers entered in form locator 50 a-c. The member’s nine-digit SoonerCare identification number is required and should be listed in the same order as form locator 50 a-c. Other carriers are optional. <i>Required</i>
61A – 61C	GROUP NAME <i>Not captured</i>
62A – 62C	INSURANCE GROUP NO. <i>Not captured</i>
63A – 63C	TREATMENT AUTHORIZATION CODES <i>Not captured</i>
64A – 64C	DOCUMENT CONTROL NUMBER <i>Not captured</i>
65A – 65C	EMPLOYER NAME <i>Not captured</i>
66	DX <i>Not captured</i>
67	PRIN. DIAG. CD. – Enter the ICD diagnosis code describing the principal diagnosis. <i>Required</i>

Form Locator	UB-04 Field Description/Explanation
67 A-Q	OTHER DIAG. CODES – Enter the ICD diagnosis codes corresponding to additional conditions that exist at the time of admission or that develop subsequently and have an effect on the treatment received or the length of stay. When submitting an inpatient claim, enter the Point of Admission (POA) codes for each diagnosis entered. <i>Required, if applicable</i>
68	Unlabeled field <i>Not captured</i>
69	ADM. DIAG. CD – Enter the ICD diagnosis code provided at the time of admission as stated by the physician. <i>Required</i>
70	<i>Not captured</i>
71	<i>Not captured</i>
72 a-c	ECI – “a” is the only field captured. <i>Optional; b and c are not captured.</i>
73	<i>Not captured</i>
74	PRINCIPAL PROCEDURE CODE/DATE – Enter the ICD-CM procedure code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed. Do not use HCPCS or CPT codes. <i>Required for surgery</i>
74 a-e	OTHER PROCEDURE CODE/DATE – Enter the ICD-CM procedure codes identifying the significant procedures other than the principal procedure and the dates identified by codes on which the procedures were performed. Report the most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. Do not use HCPCS or CPT codes. <i>Optional</i>
75	<i>Not captured</i>
76	ATTENDING PHYS. ID: NPI <i>Required, if applicable</i>
77A	OTHER PHY. ID: NPI <i>Required, if applicable</i>
78-79	<i>Not captured</i>
80-81	<i>Not captured</i>

DIRECT DATA ENTRY (DDE) CLAIM SUBMISSION – INSTITUTIONAL

Use the Institutional claim form example and the directions below as guides when submitting a claim through DDE on the SoonerCare Provider Portal. Required fields are indicated. To access this form, choose the Submit Claim Inst claim option (see Screen Sample 6.4) from the Claims menu. Fields with an asterisk (*) are always required. Other fields may be required under certain circumstances.



Screen Sample 6.4

Detailed Instructions on specific OHCA requirements on acceptable codes are located in the corresponding UB-04 form (Screen Sample 6.5) locator information. Choose the option for Institutional to obtain the fields.

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Inpatient

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	ID Type	NPI	Name
Zip Code 74006-2495	Contract Code	DM	Taxonomy
Institutional Provider ID	ID Type	NPI	SC Provider Number
Attending Provider ID <input type="text"/>	ID Type ▼		
Operating Provider ID <input type="text"/>	ID Type ▼		
Referring Provider ID <input type="text"/>	ID Type ▼		

Patient Information

General Patient Instructions

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Claim Header Instructions

*Covered Dates <input type="text"/> - * <input type="text"/> *Admission Date/Hour <input type="text"/> (hh:mm) *Admission Type <input type="text"/> *Admitting ICD Version ICD-9-CM ▼ *Patient Status <input type="text"/> Patient Account Number <input type="text"/>	Covered Days <input type="text"/> Discharge Hour <input type="text"/> (hh:mm) *Admission Source <input type="text"/> *Admitting Diagnosis <input type="text"/> *Type of Bill <input type="text"/> Other Insurance Include ▼
--	---

Total Charged Amount \$0.00

Screen Sample 6.5

Diagnosis Codes -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	POA	Action
1				
1	*ICD Version <input type="text" value="ICD-9-CM"/>	*Diagnosis Code <input type="text"/>		
	Present on Admission <input type="text"/>			
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

Emergency Diagnosis Code -

Only one emergency diagnosis code is allowed per claim.

ICD Version Diagnosis Code

Other Insurance Details -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Payer Code	Prior Amount	Estimated Amount Due	Action
1				
1	*Payer Code <input type="text"/>	*Prior Amount <input type="text"/>	Estimated Amount Due <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

Condition Codes -

Click the **Remove** link to remove the entire row.

#	Condition Code	Action
1		
1	*Condition Code <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>		

Occurrence Codes -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Occurrence Code	From Date	To Date	Action
1		-	-	
1	*Occurrence Code <input type="text"/>	*From Date <input type="text"/>	*To Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

Value Codes -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Value Code	Amount	Action
1			
1	*Value Code <input type="text"/>	*Amount <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>			

Surgical Procedures -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st surgical procedure code entered is considered to be the principal (primary) Surgical Procedure Code.

#	Surgical Procedure Type	Surgical Procedure Code	Date	Action
1			-	
1	*Surgical Procedure Type <input type="text" value="ICD-9-CM"/>	*Surgical Procedure Code <input type="text"/>	*Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

Screen Sample 6.5 continued

Service Details							
Select the row number to edit the row. Click the Remove link to remove the entire row.							
Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1							
1	*Revenue Code	HCPCS/Proc Code					
	Modifiers						
	*From Date	To Date			*Units 1.000	*Unit Type Unit	
	DMH Contract Source	*Charge Amount					
<input type="button" value="Add"/> <input type="button" value="Reset"/>							
Attachments							
Click the Remove link to remove the entire row.							
#	Transmission Method	File	Control #	Attachment Type	Action		
Click to add attachment.							
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/>				<input type="button" value="Submit"/> <input type="button" value="Cancel"/>			

Screen Sample 6.5 continued

Above the Service Information heading select the Claim Type drop-down list and choose the Inpatient or Outpatient Crossover claim type. The Crossover Details section should now be visible (Screen Sample 6.6).

Medicare Crossover Details	
Institutional Medicare Crossover Instructions	
Deductible Amount	<input type="text"/>
Blood Deductible Amount	<input type="text"/>
Co-insurance Amount	<input type="text"/>
*Medicare Payment Date	<input type="text"/>

Screen Sample 6.6

Under the Crossover Details Heading enter the payment date in the Medicare Payment Date* field, if applicable.

DDE INSTITUTIONAL CLAIM SUBMISSION INSTRUCTIONS	
Provider Information	
Billing Provider ID – Your Provider ID and provider information should auto-populate. Verify that it is correct. If it is not, you need to log out and access the correct provider. <i>Required</i>	
Institutional Provider ID – Enter the institutional provider ID.	
Attending Provider ID – Enter the Oklahoma provider ID of the attending physician. Do not use the UPIN.	
Operating Provider ID – Enter the Prescriber ID number of the operating provider. Required for submitting surgical procedures.	

DDE INSTITUTIONAL CLAIM SUBMISSION INSTRUCTIONS
<p>Referring Provider ID – Enter the 10-character referral number from the Referral Form if the member is enrolled in the SoonerCare Choice program. See UB-04 form locator 83B for more information. <i>Required, if applicable</i></p>
<p>ID Type – Use the drop-down list to select the ID types used for the providers</p>
Patient Information
<p>Member ID – Enter the member’s Oklahoma SoonerCare ID number in the Client ID field. If the member ID entered is found in the system, the patient’s last name and first name along with Birth Date will auto-populate. <i>Required</i></p>
Claim Information
<p>Covered Dates – Enter the dates of coverage. <i>Required</i></p>
<p>Covered Days – Enter the number of eligible days in the Covered Days field. Required for inpatient and nursing home facilities. See UB-04 form locator 7 for more information.</p>
<p>Admission Date/Hour – Enter date of admission and time of admission (in 24 hour format) in the Admission Date field <i>Required, if applicable</i></p>
<p>Discharge Hour – Enter time of discharge using 24-hour format (for example: 7:00 PM = 19:00) in the Discharge Time field. <i>Required, if applicable</i></p>
<p>Admission Type – Enter at least one character to begin searching for an admission type in the Admission Type field. <i>Required, if applicable</i></p>
<p>Admission Source – Enter at least once character to begin searching for an admission source in the Admission Source field. <i>Required, if applicable</i></p>
<p>Admitting ICD Version – Use the drop-down list to select a diagnosis type. <i>Required, if applicable</i></p>
<p>Admitting Diagnosis – Enter a diagnosis code in the Admitting Diagnosis field. Admission and Primary diagnosis are required for inpatient and nursing home services. <i>Required, if applicable</i> See UB-04 Form Locators 67-75 for more information.</p>

DDE INSTITUTIONAL CLAIM SUBMISSION INSTRUCTIONS
<p>Patient Status – Enter at least two characters to begin searching for a patient status. <i>Required</i></p>
<p>Type of Bill – enter the three-digit bill code number in the Type of Bill field. First digit identifies Type of Facility. Second digit identifies Bill Classification. Third digit identifies Frequency. All positions must be fully coded. Please consult the National UB-04 Uniform Billing Manual for bill code types. <i>Required</i></p>
<p>Patient Account # – Patient account number will be captured if entered into the Patient Account # field. <i>Optional</i></p>
<p>Other Insurance – Select the applicable option for other insurance.</p>
<p>Total Charged Amount – The Total Charged Amount field is automatically populated.</p>
Medicare Crossover Details (when applicable)
<p>Deductible Amount – Enter the deductible amount.</p>
<p>Co-insurance Amount – Enter the co-insurance amount.</p>
<p>Blood Deductible Amount – Enter the blood deductible amount.</p>
<p>Medicare Payment Date – Enter the payment date. <i>Required</i></p>
Diagnosis Codes
<p>ICD Version – Use the drop-down list to select a diagnosis type. <i>Required</i></p>
<p>Diagnosis Code – Enter at least three characters to begin searching for a diagnosis code. <i>Required</i></p>
<p>Present on Admission – Use the drop-down list to select a response. <i>Inpatient only</i></p>
Emergency Diagnosis Codes
<p>ICD Version – Use the drop-down list to select a diagnosis type.</p>
<p>Diagnosis Code – Enter at least three characters to begin searching for a diagnosis code.</p>
Other Insurance Details (When Other Insurance-Include is selected)

DDE INSTITUTIONAL CLAIM SUBMISSION INSTRUCTIONS
Payer Code – Use the drop-down list to select the other insurance type.
Prior Amount – Enter the prior amount.
Estimated Amount Due – Enter the estimated amount due.
Condition Codes
Condition Code – Enter at least two characters to begin searching for a condition code. <i>Optional</i>
Occurrence Codes
Occurrence – Enter at least two characters to begin searching for an occurrence code. See UB-04 form locator 32-36 for specific code information. <i>Required, if applicable</i>
From Date – Enter a beginning date. <i>Required, if applicable</i>
To Date – Enter an end date. <i>Required, if applicable</i>
Value Codes
Value Code – Enter at least two characters to begin searching for value codes. <i>Required, if applicable</i>
Amount – Enter a dollar amount with cents; for example: Correct: 45.00; Incorrect: \$45 <i>Required, if applicable</i>
Surgical Procedures (When Operating Provider Number is Entered in Provider Information)
Surgical Procedure Type – Use the drop-down list to select a procedure type. <i>Required, if applicable</i>
Surgical Procedure Code – Enter at least three characters to begin searching for surgical procedure codes. <i>Required, if applicable</i>
Date – Enter a date. <i>Required, if applicable</i>
Service Details
Revenue Code – Enter the three-digit revenue code in the Revenue Code field. Do not use the 001 revenue code for DDE claims. <i>Required</i>

DDE INSTITUTIONAL CLAIM SUBMISSION INSTRUCTIONS
<p>HCPCS/Proc Code – Enter the five-digit HCPCS or CPT procedure code in the HCPCS/Proc Code field. <i>Required, if applicable</i> See UB-04 form locator 44 for more information.</p>
<p>Modifiers – Enter the modifiers in the Modifiers field. <i>Required, if applicable</i></p>
<p>From Date – Enter a date in which the service performed started. <i>Required</i></p>
<p>To Date – Enter a date in which the service performed ended.</p>
<p>Units – Enter the number of units billed at the detail level in Units field. <i>Required</i> See UB 04 form locator 46 for more information.</p>
<p>Unit Type – Indicate the type of measurement by using the drop-down list. <i>Required</i></p>
<p>DMH Contact Source – Enter a contract source in the DMH contract source field. <i>Required, if applicable</i></p>
<p>Charge Amount – Enter the amount billed (units billed multiplied by the rate) in the Charge Amount field. <i>Required</i></p>
NDC for Item # (Outpatient and Home Health)
<p>Code Type – Select from the drop-down list to determine the type of code used.</p>
<p>NDC/UPN – Enter the NDC or UPN code in the Procedure field.</p>
<p>Quantity – Enter the quantity.</p>
<p>Unit of Measure – Select the drop-down list to determine the type of measurement.</p>
<p>If additional items are to be billed on this submission, click Add next to the line item window and repeat process. Click Remove to remove a line entry.</p>
Attachments
<p>Transmission Method – Select the drop-down list to determine how attachments will be sent. <i>Required, if applicable</i></p>
<p>Upload File – Click Browse to locate file being uploaded; available when selecting FT-File Transfer. <i>Required, if applicable</i></p>
<p>Attachment Type – Select the drop-down list to determine the type of file.</p>

DDE INSTITUTIONAL CLAIM SUBMISSION INSTRUCTIONS
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<i>Required, if applicable</i>

<p>If a hard-copy attachment is to be added, a system-generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission See Section F in this chapter for instructions on sending HCA-13 form by fax or mail.</p>
--

<p>Unique ACNs (Control #s) are generated once an attachment has been added. <i>Required, if applicable</i></p>

<p>Description – Enter a description of the attachment. <i>Required, if applicable</i></p>
--

<p>Submit - When finished, click Submit. <i>Required</i></p>

SECTION D: ADA 2012, DENTAL, 837D

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION															
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX															
2. Predetermination/Preauthorization Number					POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION															
3. Company/Plan Name, Address, City, State, Zip Code															
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)					12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)					13. Date of Birth (MM/DD/CCYY)		14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)					16. Plan/Group Number		17. Employer Name								
PATIENT INFORMATION															
6. Date of Birth (MM/DD/CCYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)			18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Reserved For Future Use					
9. Plan/Group Number			10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other							20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code															
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)										
RECORD OF SERVICES PROVIDED															
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Cpt	30. Description	31. Fee						
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
33. Missing Teeth Information (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)			31a. Other Fee(s)							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
34a. Diagnosis Code(s) (Primary diagnosis in "A")										A _____ C _____		32. Total Fee		\$0.00	
34b. Diagnosis Code(s) (Secondary diagnosis in "B")										B _____ D _____					
35. Remarks															
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.					38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")			39. Enclosures (Y or N) <input type="checkbox"/>							
X Patient/Guardian Signature _____ Date _____					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					42. Months of Treatment		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)						
X Subscriber Signature _____ Date _____					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)					46. Date of Accident (MM/DD/CCYY)					47. Auto Accident State					
48. Name, Address, City, State, Zip Code					TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
49. NPI					50. License Number		51. SSN or TIN								
52. Phone Number					52a. Additional Provider ID		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X _____ Date _____ Signed (Treating Dentist)								
54. NPI					55. License Number		56. Address, City, State, Zip Code								
57. Phone Number					57a. Additional Provider ID		58. Provider Specialty Code								

©2012 American Dental Association
 J450D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
 or go online at adacatalog.org

ADA 2012 Field Description

The ADA 2012 paper claim form is the required claim form used by dental providers for dental service billing. The provider is responsible for purchasing the ADA 2012 paper claim form. This

section explains how to complete a paper ADA 2012 claim form. Please mail paper claims to the appropriate mailbox address below: The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

Dental ADA form

HP Enterprise Services

P.O. Box 18110

Oklahoma City, OK 73154

Form Locator	ADA 2012 Field Description/Explanation
1	Type of Transaction – Enter an X in the appropriate box. Use the EPSDT/TXIX box or Oklahoma SoonerCare billing. <i>Required</i>
2	Predetermination/Preauthorization Number <i>Optional</i>
3	Primary Payer Information <ul style="list-style-type: none"> • Carrier Name – Enter SoonerCare here. • Carrier Address – Enter the P.O. Box, which can be found in the General Information chapter of this manual. • City – Enter the city name. • State – Enter the two-letter initial of the state. • Zip – Enter the Zip code. <i>Optional</i>
4	Other Dental or Medical Coverage? – Enter an X in the appropriate box. <i>Required, if applicable</i>
5	Name of Policyholder/Subscriber – The dental insurance carrier name goes in this field. This carrier must be billed before billing Oklahoma SoonerCare. <i>Required, if applicable</i>
6	Date of Birth – This field is not used for Oklahoma SoonerCare billing.
7	Gender – Enter an X in the appropriate box. <i>Optional</i>
8	Subscriber Identifier (SSN or ID#) – This field is not used for Oklahoma SoonerCare billing.
9	Plan/Group Number – Enter the number of the insurance company here. <i>Optional</i>
10	Patent's Relationship to Person Named in # 5 – Check appropriate box. <i>Optional</i>

Form Locator	ADA 2012 Field Description/Explanation
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code – This field is used for payment information and/or denial information from the patient’s other dental insurance. If a payment is received from patient’s primary insurance, put the amount of the payment in this field (for example, 45.00). You do not need to use a dollar sign (\$). If the primary insurance carrier did not make reimbursement, write the words, “Carrier Denied” in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims. <i>Required, if applicable</i>
12	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code - Enter the member’s name in last name, first name, middle name order as it appears on their eligibility file. <i>Optional</i>
13	Date of Birth –This field is not used for Oklahoma SoonerCare billing. <i>Optional</i>
14	Gender – Enter an X in the appropriate box. <i>Optional</i>
15	Patient ID/Account # – This field is not used for Oklahoma SoonerCare billing. <i>Optional</i>
16	Plan/Group Number – Enter the member’s or employer group’s plan or policy number. This may also be known as the certificate number. <i>Optional</i>
17	Employer Name – Enter SoonerCare. <i>Optional</i>
18	Relationship to Member/Employee: – Check the Self box. <i>Optional</i>
19	Student Status – Check appropriate box, if applicable. <i>Optional</i>
20	Policyholder/Subscriber Name – Enter the member’s name in last name, first name, middle initial order, address, city, state, and zip code. <i>Required</i>
21	Date of Birth (MM/DD/YY) – Enter member’s date of birth using MM/DD/YY format. <i>Optional</i>

Form Locator	ADA 2012 Field Description/Explanation
22	Gender – Enter an X in the appropriate box. <i>Optional</i>
23	Policyholder/Subscriber ID (SSN or ID) – Enter patient’s nine-digit Oklahoma SoonerCare ID number. <i>Required</i>
24 through 31 – Only one unit may be billed per detail line.	
24	Procedure Date – The date of service must be entered in MM/DD/CCYY format. <i>Required</i>
25	Area of Oral Cavity – The following are the only acceptable quadrants: UL–Upper Left UR–Upper Right LL–Lower Left LR–Lower Right <i>Required, if applicable</i>
26	Tooth System <i>Optional</i>
27	Tooth Number(s) or Letter(s) – (if applicable). Must use the international tooth numbering system for permanent, primary teeth, and supernumerary teeth. <i>Required, if applicable</i>
28	Tooth Surface - The following are the only acceptable surfaces: M-Mesial D-Distal O-Occlusal L-Lingual F-Facial B-Buccal I-Incisal <i>Required, if applicable</i>
29	Procedure Code – This is the five-digit HCPCS code listed in the current HCPCS Level II code book. <i>Required</i>
29a	Diagnosis Code Pointer – Enter the letter(s) from Item 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first. <i>Required if applicable</i>
29b	Quantity – Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the member on the date of service shown in Item 24. <i>Required</i>
30	Description – Use this field to enter any additional information. <i>Optional</i>
31	Fee - Enter your customary fee for the procedure. <i>Required</i>

Form Locator	ADA 2012 Field Description/Explanation
31a	Other Fee(s) – Payment amounts made by other insurance plans. This field is not used for Oklahoma SoonerCare billing.
32	Total Fee – Enter the total of column 31 charges. Each page must have a total. Claims cannot be continued to two or more pages. <i>Required</i>
33	Place an X on each missing tooth – Identify the missing teeth by using the international tooth numbering system for permanent and primary teeth to mark an X on numbers and letters corresponding with those teeth. <i>Optional</i>
34	Diagnosis Code Qualifier – Enter the appropriate code to identify the diagnosis code source: B = ICD-9-CM AB = ICD-10-CM <i>Optional</i>
34a	Diagnosis Code – Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter “A”. <i>Required if applicable</i>
35	Remarks <i>Optional</i>
36	Patient/Guardian Signature – Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.
37	Subscriber Signature - Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.
38	Place of Treatment – Enter the two-digit Place of Service Code for Professional Claims. Frequently used codes are: 11 = Office 12 = Home 21 = Inpatient Hospital 22 = Outpatient Hospital 31 = Skilled Nursing Facility 32 = Nursing Facility <i>Required, if applicable</i>
39	Number of Enclosures (00-99) <i>Optional</i>

Form Locator	ADA 2012 Field Description/Explanation
40	Is treatment for orthodontics? – Enter X in appropriate box. If the No box is marked, skip form locators 41 and 42. <i>Optional</i>
41	Date Appliance Placed (MM/DD/CCYY) – Enter date orthodontic appliance was placed. <i>Optional</i>
42	Months of Treatment Remaining – Enter number of months of treatment remaining for appliance. <i>Optional</i>
43	Replacement of Prosthesis? – Enter X in appropriate box. <i>Optional</i>
44	Date Prior Placement (MM/DD/CCYY) – Enter date of previous placement. <i>Optional</i>
45	Treatment Resulting From – Check applicable box. <i>Required, if applicable</i>
46	Date of Accident – Enter date accident occurred in MM/DD/CCYY format. <i>Optional</i>
47	Auto Accident State – Enter state where accident occurred. <i>Optional</i>
48	Name, Address, City, State, Zip Code of Billing Dentist or Billing Entity – Enter the name, address and zip code of dentist requesting payment for services listed on claim form. If the dentist furnished the services as part of a dental group practice, enter the name, address, zip code and telephone number of the dental group practice. <i>Required</i>
49	NPI – Enter the NPI for the pay-to provider if the services were furnished as part of a group practice. <i>Optional</i>
50	License Number <i>Optional</i>
51	SSN or TIN <i>Optional</i>
52	a – Enter the phone number, including area code, of the billing dentist telephone number for the billing provider's office. <i>Optional</i>

Form Locator	ADA 2012 Field Description/Explanation
52a	Enter the 10-character Oklahoma SoonerCare provider number for the billing group. <i>Required, if dentist is part of a group</i>
53	Treating Dentist's signature and date of claim – The name of the treating dentist and the date the claim was created. A signature stamp is acceptable; however, writing "Signature on File" is not allowed. <i>Required</i>
54	NPI – Enter the NPI of the individual dentist providing the service. <i>Optional</i>
55	Dentist License # – Enter the license number of the billing dentist. <i>Optional</i>
56	Address, City, State, Zip Code where treatment was performed Address – Enter address if different from address indicated in box 48. <i>Required, if applicable</i> City – Enter city if different from city indicated in box 48. <i>Required, if applicable</i> State – Enter two-letter state initial if different from state indicated in box 48. <i>Required, if applicable</i> Zip Code – Enter zip code if different from zip code indicated in box 48. <i>Required, if applicable</i> 56A. Provider Specialty Code. Enter the treating provider's specialty area. <i>Optional</i>
57	Phone Number – Enter phone number of office where treatment was performed. <i>Optional</i>
58	Additional Provider ID – Enter the rendering dentist's 10-character Oklahoma SoonerCare provider number. <i>Required</i>

Direct Data Entry (DDE) Claim Submission - Dental

Use the Dental claim form example and directions below as guides when submitting a claim through DDE on the SoonerCare Provider Portal. Required fields are indicated in the directions. Choose the Submit Dental Claim (see Screen Sample 6.7) claim option from the Claims menu to open the form (Screen Sample 6.8).



Screen Sample 6.7

Submit Dental Claim: Step 1 ?

* Indicates a required field.

Provider Information

General Provider Header Instructions

Billing Provider ID	ID Type NPI	Name
Zip Code 74501-5443		SC Provider Number

Patient Information

General Patient Instructions

*Member ID <input type="text"/>		
Last Name	First Name	Middle
Birth Date		

Claim Information

General Claim Information Instructions

Accident Related <input type="text"/>	Emergency <input type="text"/>
*Place of Treatment 11-Office <input type="text"/>	Patient Account Number <input type="text"/>
Other Insurance None <input type="text"/>	

Total Charged Amount \$0.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

1 *ICD Version ICD-9-CM *Diagnosis Code

Other Insurance Details -

TPL Amount

Screen Sample 6.8

Service Details								
Select the row number to edit the row. Click the Remove link to remove the entire row.								
Svc #	Svc Date	Oral Cavity Area		Tooth Number	Procedure Code	Units	Charge Amount	Action
1								
1	*Svc Date	Oral Cavity Area		Tooth Number				
	Tooth Surface						Prosthesis	
	Cavity Code							
	*Procedure Code	Modifiers						
	*Units	*Charge Amount						
	Rendering Provider ID	ID Type	Zip Code		SC Provider Number			
<input type="button" value="Add"/> <input type="button" value="Reset"/>								
Attachments								
Click the Remove link to remove the entire row.								
#	Transmission Method	File	Control #	Attachment Type	Action			
	*Transmission Method	FT-File Transfer						
	*Upload File			<input type="button" value="Browse..."/>				
	*Attachment Type							
	Description							
<input type="button" value="Add"/> <input type="button" value="Cancel"/>								
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/>				<input type="button" value="Submit"/> <input type="button" value="Cancel"/>				

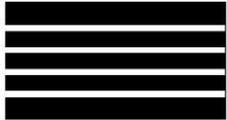
Screen Sample 6.8 continued

DDE DENTAL CLAIM SUBMISSION INSTRUCTIONS
Billing Information
Billing Provider ID – Your Provider ID should appear in the first box. Confirm it is correct. If it is not, you may need to log out and access the correct provider/ <i>Required</i>
Patient Information
Member ID – Enter the member’s Oklahoma SoonerCare ID number in this field. The patient’s last name and first name along with Birth Date will auto-populate if the member ID entered is found in the system <i>Required</i>
Diagnosis Codes
ICD Version – Use the drop-down list to select a diagnosis type. <i>Required if applicable</i>
Diagnosis Code – Enter at least three characters to begin searching for a diagnosis code. <i>Required if applicable</i>

DDE DENTAL CLAIM SUBMISSION INSTRUCTIONS
Claim Information
Accident Related – Use the drop-down list to further describe the accident. <i>Required, if applicable</i>
Emergency – Specify whether the claim was an emergency by selecting Yes or No from the drop-down list. <i>Optional</i>
Place of Treatment – Select the appropriate place of treatment from the drop-down list. <i>Required</i>
Patient Account Number – The patient account number will be captured and appear on the remittance advice, if entered into this field.
Other Insurance – Select the applicable option for other insurance.
Total Charged Amount – Total charges are automatically populated.
Other Insurance Details (When Other Insurance-Include is selected)
TPL Amount – Enter the TPL amount
Service Details
Svc Date – Enter the date of service here. <i>Required</i>
Oral Cavity Area – Use the drop-down list to select the cavity area.
Tooth Number – Use the drop-down list to select a tooth number in this field. <i>Required, if applicable</i>
Tooth Surface – Use the drop-down list to a select a surface type in this field. <i>Required, if applicable</i>
Prosthesis – Use the drop-down list to select a prosthesis type.
Cavity Code – Enter modifier codes in the Cavity Code fields <i>Required, if applicable</i>
Procedure Code – Enter the procedure code in this field. <i>Required</i>
Modifiers – Enter up to four modifiers.
Units – Enter number of units billed in this field. <i>Required</i>
Charge Amount – Enter the total dollar amount of charges in this field for this line of service. <i>Required</i> This action will auto-populate the Total Charges field, but it will not multiply the amount by the number of units.

DDE DENTAL CLAIM SUBMISSION INSTRUCTIONS
Rendering Provider ID – Enter the SoonerCare provider identification number of the dentist performing the services. The Rendering Provider fields display for the first service line only.
ID Type – Use the drop-down list to select an ID type. <i>Required, if applicable</i>
Zip Code – Enter the Zip code of the rendering provider.
SC Provider Number – Enter the SoonerCare provider number.
If additional items are to be billed on this submission, click Add next to the line item window and repeat process. Click Remove to remove a line entry.
Attachments
Transmission Method – Select from the drop-down list to determine how attachments will be sent. <i>Required, if applicable</i>
Upload File – Click Browse to locate file being uploaded; available when selecting FT-File Transfer. <i>Required, if applicable</i>
Attachment Type – Select the drop-down list to determine the type of file. <i>Required, if applicable</i>
Description – Enter a description of the attachment.
If a hard-copy attachment is to be added, a system generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list. See Section F in this chapter for instructions on sending form HCA-13 by fax or mail. Unique ACN's (Control #) are generated once an attachment is added. <i>Required, if applicable</i>
Submit – When finished, click Submit .

SECTION E: DRUG/COMPOUND PRESCRIPTION DRUG, PHARMACY, NCPDP



State of Oklahoma
Oklahoma Health Care Authority
Prescription Drug Claim Form

PLEASE PRINT CLEARLY

Provider Number (required) 01	Loc (req) 02	Billing NPI (optional) 03	Telephone Number 04		
Patient's Name: Last, First (required) 05	Member ID (Required) 06	Member's Date of Birth (Required mmddccyy) 07	Emergency (Y or N) 08	Pregnancy (Y or N) 09	NH Pt. (Y or N) 10
Prescription Number (Required) 11	Date Prescribed (Required) 12	Date Dispensed (Required) 13	NDC Number (Required) 14	Quantity (required) 15	Days 16
Brand Medically Necessary 17	Refill 18	Individual Prescriber's ID Number (Required) 19	Individual Prescriber's Name: Last, First (Required) 20		
Charge (Required) 21	Third Party Paid 22	Total Amount Billed (Required) 23	Usual and Customary 24		

Provider's Name and Address 25	This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law. I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.
	<div style="width: 60%;">Signature of Provider or Representative (Required) 26</div> <div style="width: 35%;">Date Billed (Required) 27</div>

Mail Completed Claim Form to:
 EDS
 P.O. Box 18650
 Oklahoma City, OK 73154

OKLA HCA Revised 04/17/2007

PHARM-1

Field Descriptions for Drug/Compound Claim Forms

The Drug/Compound Drug Claim Forms are used to bill pharmacy services and are available in the Forms chapter of this manual and on the OHCA web site at www.okhca.org.

Pharmacy Claim submissions are done through the Drug Claim Form (Pharm-1 revised 4/17/2007) and Compound Prescription Drug Claim Form (Pharm-2). These claim forms should be used for every pharmacy paper billing, including the resubmission of a claim that is more than one year past date of service. The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

Please mail paper claims to:

Pharmacy

HP Enterprise Services
P.O. Box 18650
Oklahoma City, OK 73154

Form Locator	Pharmacy Drug Field Description/Explanation
01	Provider Number – Enter the 9 numeric Oklahoma SoonerCare provider number. <i>Required</i>
02	Loc – Enter the alpha location code of the Oklahoma SoonerCare provider number. <i>Required</i>
03	Billing NPI – Enter the NPI of the billing provider <i>Optional</i>
04	Telephone Number <i>Optional</i>
05	Patient’s Name – Enter the patient’s name in last, first format. <i>Required</i>
06	Member ID Number – Enter the patient’s nine-character Oklahoma SoonerCare identification number. <i>Required</i>
07	Member’s Date of Birth – Enter the member’s date of birth in a month, day, century, year in mmddccyy format. <i>Required</i>
08	Emergency – Enter Y for Yes or N for No if prescription is related to an accident. <i>Optional</i>
09	Pregnancy– Enter Y for Yes or N for No if prescription is related to a pregnancy. <i>Optional</i>

Form Locator	Pharmacy Drug Field Description/Explanation
10	NH Pt. – Enter Y for Yes or N for No if prescription was dispensed to a resident of a nursing home facility. <i>Optional</i>
11	Prescription Number – Enter the pharmacy’s prescription number. May be up to seven characters in length. <i>Required</i>
12	Date Prescribed – Enter the date the prescription was written. Must be on or before receipt date; not a future date <i>Required</i>
13	Date Dispensed – Enter the date the prescription was dispensed. Must be on or before receipt date; cannot be future date. <i>Required</i>
14	NDC Number – Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. <i>Required</i>
15	Quantity – Enter the metric quantity to three decimal places, up to 11 characters. Example: 99999999.999 <i>Required</i>
16	Days– Enter the number of days’ supply dispensed. May be up to three characters. <i>Required</i>
17	Brand Medically Necessary – Enter the appropriate brand name indicator as indicated below: 0 – No product selection indicated 1 – Substitution not allowed by prescriber – Dispense as written. <i>Required, if applicable</i>
18	Refill – Enter two digits to indicate the number of times the prescription has been dispensed. Example: 00 = original dispensing, 01 to 99 = refill number. <i>Required</i>
19	Individual Prescriber’s ID Number – Enter the seven-digit Oklahoma Prescriber ID number of the prescribing physician. <i>Required</i>
20	Individual Prescriber’s Name – Enter the prescriber’s name. Last name followed by first name. <i>Required</i>
21	Charge – Enter the charge for this prescription. <i>Required</i>

Form Locator	Pharmacy Drug Field Description/Explanation
22	Third Party Paid – Enter the amount paid by the primary insurance (TPL). <i>Required, if applicable</i>
23	Total Amount Billed – Enter the total amount billed. Charge – TPL = total amount billed. <i>Required</i>
24	Usual and Customary – Enter the usual and customary charge for the quantity and NDC provided. <i>Required</i>
25	Provider's Name and Address – Enter the billing provider's name, address and telephone number. <i>Optional</i>
26	Signature of Provider or Representative - This must be an authorized name of a person indicating that the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable, but writing <i>signature on file</i> is not acceptable. <i>Required</i>
27	Date Billed - Enter the date the bill is submitted in MMDDYY format. <i>Required</i>



**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
COMPOUND PRESCRIPTION
DRUG CLAIM FORM**

PLEASE PRINT CLEARLY

<small>Provider Number</small>		<small>Loc</small>	<small>Telephone Number</small>	
1		2		
<small>PATIENT'S NAME: LAST, FIRST</small>			<small>CLIENT NO.</small>	<small>PRESCRIBER'S ID NUMBER</small>
3		4		5
<small>PRESCRIPTION NUMBER</small>	<small>DATE PRESCRIBED</small>	<small>DATE DISPENSED</small>	<small>LOCAL USE ONLY</small>	<small>DAYS</small>
11		12		13
<small>NDC NUMBER</small>		<small>DESCRIPTION OF DRUG/REGIMENT</small>		<small>QUANTITY</small>
<small>LINE NUMBER</small>	<small>21</small>	<small>22</small>		<small>23</small>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

18 Provider's Name and Address

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of
Provider or Representative

Date Billed

19

20

MAIL COMPLETED CLAIM FORM TO: □
EDS
P.O. Box 18650
Oklahoma City, OK 73154

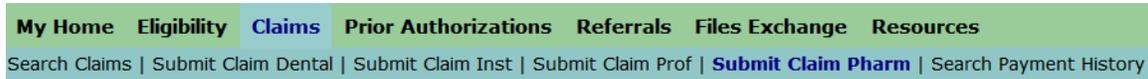
Compound Prescription Drug Claim Form Instructions

Form Locator	Compound Prescription Drug Field Description/Explanation
1	Provider Number – Enter the 10-character Oklahoma SoonerCare provider number and Location code. <i>Required</i>
2	Telephone Number <i>Optional</i>
3	Patient’s Name – Enter the member’s name in last, first format. <i>Required</i>
4	Client ID Number – Enter the member’s nine-character Oklahoma SoonerCare identification number. <i>Required</i>
5	Prescriber ID Number – Enter the seven-digit Oklahoma Prescriber ID number of the prescribing physician (<i>Required</i>)
6	Emerg – Enter Yes or No if prescription is related to an emergency. <i>Optional</i>
7	Preg – Enter Yes or No if prescription is related to a pregnancy. <i>Optional</i>
8	N. H. PAT – Enter Yes or No if prescription was dispensed to a resident of a nursing home facility <i>Optional</i>
9	Brand – Brand Name Indicator 0 – No product selection indicated 1 – Substitution not allowed by prescriber – Dispense as written. <i>Required, if applicable</i>
10	Refill – Refill Indicator. Enter two digits to indicate the number of times the prescription has been dispensed. Example: 00 = original dispensing, 01 to 99 = refill number. <i>Required</i>
11	Prescription Number – Enter the pharmacy’s prescription number. May include up to seven characters. <i>Required</i>
12	Date Prescribed – Enter the date the prescription was written. Must be on or before receipt date; not a future date. <i>Required</i>

Form Locator	Compound Prescription Drug Field Description/Explanation
13	Date Dispensed – Enter the date the prescription was dispensed. Must be on or before receipt date; not a future date. <i>Required</i>
14	Local Use Only <i>Not applicable</i>
15	Days – Enter the number of days’ supply dispensed. May be up to three characters. <i>Required</i>
16	Charge - Enter the total charges for this claim. <i>Optional.</i>
17	3 rd PTY Paid – Enter the amount paid by the primary insurance. <i>Required, if applicable</i>
Service Lines	
21	NDC Number - Enter the 11-digit National Drug Code (NDC) number of each of the drugs dispensed. <i>Required</i>
22	Description of Ingredient – List each ingredient with the corresponding NDC. <i>Required</i>
23	Quantity – List the quantity of each ingredient in this compound drug.
Billing Information	
18	Provider’s Name and Address – Provider name, address and telephone number. <i>Optional</i>
19	Signature of Provider or Representative - This must be an authorized name of a person indicating that the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable, but writing signature on file is not acceptable. <i>Required</i>
20	Date Billed/Date of Claim Submission - Enter the date the bill is submitted in MMDDYY format. <i>Required</i>

DIRECT DATA ENTRY (DDE) CLAIM SUBMISSION – PHARMACY (INCLUDING COMPOUNDS)

Use the Pharmacy claim form example and directions below as guides when submitting a claim through DDE the SoonerCare Provider Portal. Choose the Submit Pharmacy claim option (see Screen Sample 6.9) from the Claims drop-down menu to access the form (Screen Sample 6.10).



Screen Sample 6.9

Submit Pharmacy Claim: Step 1 ?

* Indicates a required field.

Provider Information

This panel contains provider information.

Service Provider ID <input type="text"/>	ID Type NPI	Name
Rendering Provider NPI <input type="text"/>		SC Provider Number
		Rendering Provider Number

Patient and Claim Information

Enter information applicable to the claim. Select 'Pharmacy' or 'Compound' from the Claim Type dropdown to indicate what type of claim is being submitted. If a TPL Amount needs to be entered, then 'Other coverage exists' should be selected in the Other Coverage Code dropdown. A TPL Amount can be entered on the third step of Submit Pharmacy Claim.

*Member ID <input type="text"/>	First Name	Middle
Last Name		
*Birth Date <input type="text"/>		
Transaction Code B1-Billing		
*Claim Type <input type="text" value="1-Pharmacy"/>		
*Other Coverage Code <input type="text" value="1-No other coverage identified"/>		
Pregnancy <input type="text" value="No"/>	Emergency <input type="text" value="No"/>	Nursing Facility <input type="text" value="No"/>

Continue **Cancel**

Submit Pharmacy Claim: Step 1 ?

* Indicates a required field.

Provider Information

General Provider Header Instructions

Service Provider ID <input type="text"/>	ID Type NPI	Name
Rendering Provider NPI <input type="text"/>		SC Provider Number
		Rendering Provider Number <input type="text"/>

Patient and Claim Information

General Patient and Claim Header Instructions

*Member ID <input type="text"/>	First Name	Middle
Last Name		
*Birth Date <input type="text"/>		
Transaction Code B1-Billing		
*Claim Type <input type="text" value="1-Pharmacy"/>		
*Other Coverage Code <input type="text"/>		
Pregnancy <input type="text" value="No"/>	Emergency <input type="text" value="No"/>	Nursing Facility <input type="text" value="No"/>

Continue **Cancel**

Screen Sample 6.10

Claim Information

General Claim Information Instructions

*Prescriber ID ID Type NPI *Last Name

*Prescription # *Fill # *Date Written *Date of Service

*Days Supply

Dispense/Written

Compound Information

General Compound Information Instructions

Ingredient Component Count
0

Compound Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Compound NDC	Ingredient Quantity	Action
1			

1 *Compound NDC *Ingredient Quantity

Pricing Information

General Pricing Information Instructions

*Total Charges

DUR Override Codes

Click the **Remove** link to remove the row.

#	Reason for Service	Professional Service	Result of Service	Action
1				

1 *Reason for Service *Professional Service

*Result of Service

Other Insurance Details

General Other Insurance Detail Instructions

TPL Amount

Screen Sample 6.10 continued

PHARMACY CLAIM SUBMISSION INSTRUCTIONS
Provider Information
Service Provider ID - Your Provider ID should appear in the first box. Confirm that it is correct. If it is not, you may need to log out and access the correct provider. <i>Required</i>
Rendering Provider NPI – Display only.
Rendering Provider Number - Display only. Will default to the service provider.
Patient and Claim Information
Member ID - Enter the member's Oklahoma SoonerCare ID number in this field. <i>Required</i> (The member's last name and first name will auto-populate if the member ID entered is found in the system.)
Birth Date – Enter the date of birth of the recipient. <i>Required</i>
Claim Type – Use the drop-down list to select whether or not the prescription is a regular pharmacy claim or a compound drug pharmacy claim. <i>Required</i>
Other Coverage Code – Use the drop-down list to determine if other insurance exists or coverage has been denied.
Pregnancy – Use the drop-down list to select the appropriate answer of Yes or No indicating whether or not this prescription was related to a pregnancy. <i>Optional</i>
Emergency – Use the drop-down list to select the appropriate answer of Yes or No indicating whether or not this prescription was related to an emergency. <i>Optional</i>
Nursing Facility – Use the drop-down list to select the appropriate answer of Yes or No indicating whether or not this prescription was dispensed to a resident of a nursing home facility. <i>Optional</i>
Claim Information
Prescriber ID – Enter the Oklahoma Prescriber ID number of the prescribing physician. <i>Required</i>
ID Type – Disregard, this field will auto-populate.
Last Name – Enter the last name of the prescribing physician. <i>Required</i>

PHARMACY CLAIM SUBMISSION INSTRUCTIONS
<p>Prescription # - Enter the pharmacy assigned prescription number (up to seven digits) for the current prescription. <i>Required</i></p>
<p>Fill # – Enter two digits to indicate the number of times the prescription has been dispensed. <i>Required</i> Example: 00 = original dispensing, 01 to 99 = refill number</p>
<p>Date Written – Enter the date the prescription was prescribed by the physician. <i>Required</i></p>
<p>Date of Service – Enter the date the prescription was dispensed by the pharmacy. <i>Required</i></p>
<p>NDC – Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. (Compound will auto populate to 00000000000.) <i>Required</i></p>
<p>Quantity Dispensed – Enter the quantity being dispensed for the above NDC within the prescription. <i>Required</i></p>
<p>Days Supply – Enter the number of days the prescription will cover. <i>Required</i></p>
<p>DAW Code – Select the most appropriate option from the drop-down list to indicate if the prescription was dispensed as prescribed (dispensed as written) or if a generic medication was substituted. <i>Required</i></p>
Compound Details
<p>Compound NDC – Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. <i>Required</i></p>
<p>Ingredient Quantity – Enter the quantity of the compound/ <i>Required</i></p>
<p>Ingredient Drug Cost – Enter the cost amount of the ingredient. <i>Required</i></p>
<p>Basis of Cost Determination – Use the drop-down list to select the source behind the cost determination. <i>Optional</i></p>
Pricing Information
<p>Total Charge – Enter the usual & customary charge. <i>Required</i></p>
DUR Overrides

PHARMACY CLAIM SUBMISSION INSTRUCTIONS
Reason for Service – Use the drop-down list to select the appropriate Prospective DUR intervention used to decide outcome of claim. <i>Required, if applicable</i>
Professional Service – Use the drop-down list to select the appropriate Prospective DUR conflict message. <i>Required, if applicable</i>
Result of Service – Use the drop-down list to select the appropriate Prospective DUR outcome that was made using the intervention. <i>Required, if applicable</i>
Diagnosis Codes
Diagnosis Code Type – Use the drop-down list to select a diagnosis type. <i>Required</i>
Diagnosis Code – Enter at least three characters to begin searching for a diagnosis code. <i>Required</i>
Other Insurance Details (When Other Coverage Code-Other Coverage Exists is selected)
TPL Amount – Enter an amount in dollars and cents.
Click Submit when finished.

SECTION F: ELECTRONIC CLAIM FILING ATTACHMENT FILING

Proper filing of attachments to electronic claims is essential to the successful payment of submitted claims with attachments. An important part of the filing process is accurate entry of provider, member, and ACNs on the electronic claim form and the HCA-13 cover sheet. When submitting attachments, selecting Transmission Method Mail or By Fax (seen in Screen Sample 6.11) will generate an Electronic Claim Paper Attachment Form Cover Sheet button (seen in Screen Sample 6.12). The provider number, client ID number, claim number and ACN number will be auto-populated. See image illustrated in Screen Sample 6.13.

The screenshot shows a web form titled "Attachments". At the top, it says "Click the Remove link to remove the entire row." Below this is a table with columns: #, Transmission Method, File, Control #, Attachment Type, and Action. A checkbox labeled "Click to collapse." is next to the table. Below the table, there are fields for "Transmission Method" (with a dropdown menu), "Attachment Type" (with a dropdown menu), and "Description". The dropdown menu for "Transmission Method" is open, showing options: AA-Available on Request at Provider Site, BM-By Mail, EM-E-Mail, FT-File Transfer, and FX-By Fax. At the bottom of the form are "Add" and "Cancel" buttons.

Screen Sample 6.11

Once completed, fax the form to 405-947-3394 or mail to:

HP Enterprise Services
P.O. Box 18500
Oklahoma City, OK 73154

Helpful Tips

An Attachment Form Cover Sheet will be generated for each Transmission Method added once the claim has been submitted.

The screenshot shows a text box with instructions: "Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).", "Click **Print Preview** to view the claim details as they have been saved on the payer's system.", "Click **Edit** to resubmit the claim.", and "Click **View** to view the details of the submitted claim." Below the text box are five buttons: "Attachment Coversheet(s)", "Print Preview", "Edit", "New", and "View".

Screen Sample 6.12

Print



**Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet**

Four fields below are required and must match claim.

- 1. Provider Number**
- 2. Client ID Number**
- 3. Attachment Control Number**
- 4. Claim Number**
- 5. Date/Time**

Purpose:

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number that will be used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the identification number that was assigned to the electronically submitted claim.
4. In box 4, fill in the fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Alphabetic and numeric are the only characters that should be used in the ACN selection. Do not use dashes and spaces in the ACNs.
5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394

Note: Do not place another Fax Cover Sheet on top.

***This form is for use with electronically filed claims requiring attachments.**

Sender's Name: _____ **Phone Number:** _____

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.

OKLA HCA
Revised 06/24/09

HCA-13

Print

Close

Screen Sample 6.13

SECTION G: MEDICARE-MEDICAID CROSSOVER INVOICE

The OHCA recently developed the Medicare-Medicaid Crossover Invoice form, HCA-28, to be used when submitting paper crossover claims. Use this form as a supplement to the Medicare Explanation of Benefit (EOB) statement attachment previously required on paper cross-over claims. The new form was created due to multiple versions of the Medicare (EOB) statements being printed from the different software formats currently available. The information needed to be keyed from the Medicare EOB to process cross-over claims no longer appears in a standard format when

printed. This means the needed information to be keyed appears differently and is marked with different headers on each printed electronic Medicare EOB, making cross-over claim processing challenging. The Medicare-Medicaid Crossover Invoice form will allow these claim types to be keyed faster and more accurately by removing interpretations.

<p>SoonerCare Provider ID - Enter the 10-character SoonerCare provider ID. This consists of the nine numeric characters and one alpha character, or 10-character ID number.</p> <p><i>Required</i></p>
<p>Member ID - Enter the member's nine-character Oklahoma SoonerCare identification number.</p> <p><i>Required</i></p>
<p>Member Name - Enter the member's name in first name, last name order.</p> <p><i>Required</i></p>
<p>Patient Control Number - Enter the internal patient account number. This number will appear on the remittance advice.</p> <p><i>Required</i></p>
<p>Medicare Number - Enter the member's Medicare number.</p> <p><i>Required</i></p>
<p>From DOS to DOS - Enter the from and through dates of service as indicated on the Medicare EOB for the indicated claim using the MM/DD/YY formats.</p> <p><i>Required</i></p>

Header 2
<p>Total Billed - Enter the total amount billed for all detail lines</p> <p><i>Required</i></p>
<p>Date Paid - Enter the date the claim was paid by Medicare in the MM/DD/YY format.</p> <p><i>Required</i></p>
<p>Coinsurance/Medicare Remark Code - Enter the amount of the coinsurance for the total Medicare claim and the corresponding Medicare Remark Code(s).</p> <p><i>Required, if applicable</i></p>
<p>Deductible - Enter the amount of the deductible for the total Medicare claim and the corresponding Medicare Remark Code(s).</p> <p><i>Required, if applicable</i></p>
<p>Blood Deductible - Enter the amount of the indicated Blood Deductibles on the Medicare claim.</p> <p><i>Required, if applicable</i></p>
<p>Total Allowed - Enter the total allowed amount for the entire Medicare claim and the corresponding Medicare Remark Code(s).</p>

Header 2

Medicare Remark Code - Enter Medicare Remark Code(s) that corresponds to entire claim.
--

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Chapter 7

Electronic Data Interchange



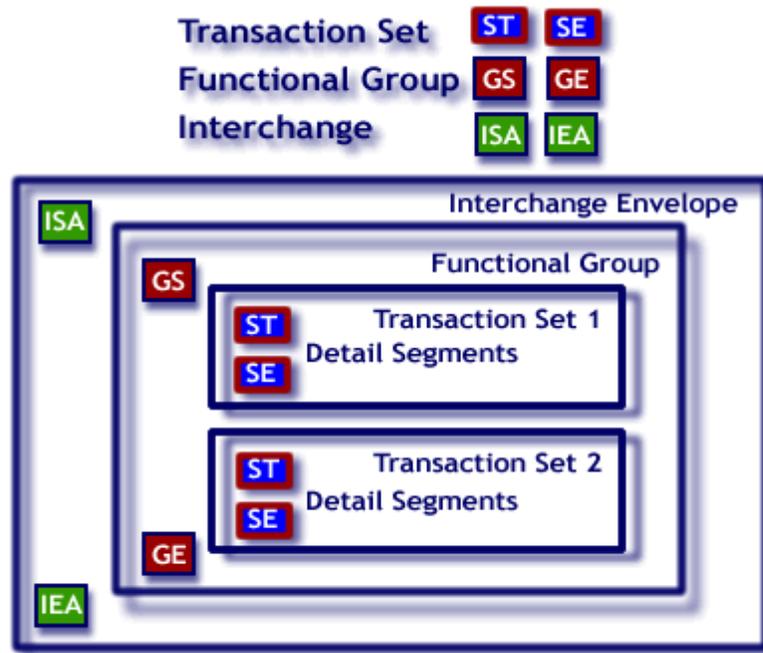
INTRODUCTION

Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Oklahoma Medicaid Management Information System (OKMMIS).

Some benefits of EDI include:

- Improved accuracy
- Lowered operating costs
- Increased cash flow
- Shorter payment turnaround time
- Ability to check claims status electronically
- Increased accounts receivable timeliness and functionality

In addition, there is no charge to providers for EDI submission. EDI transactions are sent in envelope information structures as detailed below:



The first step to becoming an electronic claims submitter is to complete an EDI application form. The form is found on the OHCA web site at www.okhca.org or by contacting the EDI Help Desk.

Providers may take advantage of the EDI process by using a billing agency, clearinghouse or VAN/third party vendor approved by the fiscal agent.

HPES promotes the use of electronic claims submissions through EDI. The EDI team is available to provide direction, answer questions and assist providers or billing agents with the submission of electronic transactions.

EDI Resources

OKMMIS-specific companion guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the OHCA public web site at: www.okhca.org.

Implementation Guides are available from the Washington Publishing Company at www.wpc-edi.com.

The EDI Help Desk can be reached by phone at 800-522-0114 or at 405-522-6205 *Option 2, 2*.

E-mail correspondence can be sent to okxixEDI@hp.com.

Written correspondence for the EDI Help Desk can be sent to:

HP Enterprise Services – EDI Help Desk

2401 NW 23rd Street, Suite 11

Oklahoma City, OK 73107

SECTION A: PROFESSIONAL CLAIMS (837 PROFESSIONAL)

837 Professional Transaction

The ASC X12N 837 Professional transaction is the electronic equivalent for the 1500 paper claim form.

Key Notes:

- No more than 50 service lines are allowed per claim.
- Typical Providers must use the 10-digit NPI as the billing/pay-to, referring, and rendering provider ID.
- For atypical providers that are not eligible for an NPI, the REF segment (Bill-to Provider's Secondary ID #) in Loop 2010AA must be included and have the "EI" field qualifier and the provider's Tax Identification #.
- The PAT segment, Loop 2000C and 2010CA, is no longer needed. All SoonerCare subscribers have their own SoonerCare ID number. When the subscriber and the patient

are the same person, omit the PAT information in Loop 2000C and 2010CA.

- The SoonerCare numbers sent on all claims:
 - Atypical Providers must use Identification
 - Typical Providers must use NPI# as primary Identification. (Please refer to the companion documents for further info regarding loops and segments).
 - Subscribers – 123456789 (9 digits)
- No more than 5,000 claims per transaction set are allowed.

SECTION B: INSTITUTIONAL CLAIMS (837 INSTITUTIONAL)

837 Institutional Transaction

The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-92 paper claim form. All hospitals and institutional facilities must use the 837 Institutional transaction to bill electronically for services covered under the SoonerCare program.

Key Notes:

- The 837 Institutional transaction must be used for inpatient claims.
- Providers must use their 10-digit NPI number as the billing/pay-to provider ID. (See companion documents for loops and segments.)
- Limit each transaction set to 5,000 claims.
- Limit each claim to a maximum of 50 service lines.
- For attending, operating and other physicians, please use only the physician's 10-digit NPI number as the primary identifier in the appropriate NM1 segment.
- The physician's taxonomy code is not used for operating physicians or physicians classified as "other."
- Do not use revenue code 001 as a total for all service lines included on the claim.
- Unit rate is required if revenue code is 100-219 (SV02-06).

SECTION C: DENTAL CLAIM (837 DENTAL)

837 Dental Transaction

The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2002 paper claim form.

Key Notes:

- No more than 50 service lines are allowed per claim.
- Providers must use the 10-digit NPI as the billing/pay-to, referral, and rendering provider ID.
- The PAT segment, Loop 2000C and 2010CA, is no longer needed unless billing a claim for a newborn. Every SoonerCare subscribers except newborns have their own SoonerCare ID number. When the subscriber and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.
- The SoonerCare numbers to be sent on claims should follow this format:
 - Providers –100000000A (9 digits with 1 letter at the end for a total of 10 characters)
 - Subscribers – 123456789 (9 digits)
- The tooth quadrant in field SV30401 must be listed.
- The TOO segment must be populated indicating tooth number and surface code.
- No more than 5,000 claims per transaction.

SECTION D: PHARMACY CLAIMS

Pharmacy Claims

All interactive electronic pharmacy claims should be submitted using the NCPDP version 5.1 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

Key Notes:

- To obtain NCPDP payer sheets, go to www.okhca.org and select the Provider link. Under Claims Tools, select the

HIPAA Companion Documents for Electronic Transaction link, then scroll down the page and select the NCPDP link.

- 3C version is no longer accepted.
- If a pharmacy is sending a compound claim, a 2 needs to be entered in field 406-D6 in the claim segment.
- If a 2 is entered in 406-D6, the compound details must be with the claim. Each NDC number must be listed.

To send test files, the pharmacy must check with their van/switch and have them send the test to the HPES test port.

SECTION E: CLAIM INQUIRIES/RESPONSES

276 Claim Inquiry Transaction (Batch)

The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific SoonerCare members. It is mandatory under HIPAA that the Oklahoma MMIS is able to accept this transaction set to create health care claim status responses.

Key Notes:

- The 276 should be limited to 5,000 inquiries per transaction set (ST-SE envelope).
- In order to return valid claim data on the 277, the data in the 276 must match the data on the claim.
- The hierarchy of the search criteria in the EDI system is:
 - NPI/Provider ID
 - Recipient ID
 - Recipient ID and Name must match
 - ICN
 - Amount Billed
 - Date of Service

277 Claim Inquiry Response Transaction (Batch)

The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or

other health care claims adjudication processors that has submitted a 276 to the OKMMIS.

Key Note:

The 277 is used solely as a response to a 276 request. The 277-Unsolicited (version 3050) is not the same thing. Refer to Section H for more information on RAs and the 277-Unsolicited.

SECTION F: ELIGIBILITY INQUIRIES/RESPONSES

270 Eligibility Inquiry Transaction (Batch)

The ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.

Key Notes

Thirteen-Month Rule – The only time to get 13 months of retrospective eligibility is at the beginning of a month. Checking at the end of the month allows you to review the past 12 months in addition to the upcoming month. Eligibility is updated toward the end of the month.

Inquiry types

- Type of insurance plan.
- Type of service performed.
- Where the service is performed.
- Where the inquiry is initiated.
- Where the inquiry is sent.

When identifying a recipient/subscriber based on the information on a 270 request, the following combinations of data are valid:

- Recipient ID only.
- SSN and DOB.
- SSN and name.
- DOB and name.
- No more than 99 inquiries per ST – SE transaction set.

271 Eligibility Inquiry Transaction

The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.

Key Notes

- The eligibility information returned is not a guarantee of claims payment.
- A value of 1 will be returned in the 271 response for a member with active coverage. This is indicated in loop 2110C - EB01.

SECTION G: REMITTANCE ADVICE (RA)

835 Remittance Advice

The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For SoonerCare, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment – via paper or electronically. The 835 transaction will be available to the OHCA providers and contracted clearinghouses requesting electronic remittance advice (ERA).

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. SoonerCare provides a supplemental transaction that provides claim status information on pending claims. This transaction is the 277 Health Care Payer Unsolicited Claim Status (X12 version 3050) and is available to every OHCA provider and contracted clearinghouse requesting ERA.

Key Notes

- Requests for changes in the delivery of an RA must be made in writing to the EDI team.
- ERAs may be combined and/or sent to a designated receiver via the provider's secure Internet account.

SECTION H: ELECTRONIC CLAIMS OR PRIOR AUTHORIZATIONS WITH PAPER ATTACHMENTS

An attachment cover sheet form HCA-13 is available for every attachment that needs to be submitted with electronic claims or electronic PA requests. HCA-13 allows claims or PA request submitters to continue billing their claims or PA requests electronically, even if an attachment needs to be sent with the claim or PA request.

To ensure proper handling of attachments:

- The attachment control number (ACN) in the PWK segment in the electronic claim or the Control field of the direct data entry page on SoonerCare Provider Portal must be identical to the ACN field on HCA-13. (See Section F of the Claims Completion chapter in this manual.)
- The provider and recipient numbers on the claim must match the provider and recipient numbers on form HCA13.
- Each submission of a claim must have a new ACN. If resubmission of a claim occurs, a counter after the original number is suggested.
- All ACNs must be unique.
- The number must be clear and legible on HCA-13. Please do not mark out information on the form. Use a new form if a mistake is made.
- When creating ACNs, avoid using
 - dashes, spaces or any other special characters;
 - ICN (claim number);
 - phone numbers;
 - patient's date of birth; and
 - patient's SSN/FEIN.
- Copies of the Attachment Cover Sheet can be obtained
 - in the Forms Chapter of this manual;
 - on the OHCA web site at www.okhca.org; or
 - by calling the HP Call Center at 405-522-6205 or 800-522-0114.

SECTION I: ELECTRONIC MEDIA TYPES

EDI transactions can be submitted to HPES via

- OHCA SoonerCare Provider Portal
- Batch upload process

EDI Batched Electronic Transactions

Batch transactions/files that are sent to HP via the OHCA SoonerCare Provider Portal or the RAS are immediately placed in the OKMMIS for processing.

SECTION J: HIPAA TRANSACTION AND CODE SET REQUIREMENTS

The Health Insurance Portability and Accountability Act (HIPAA) is a national effort driven by the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) geared toward administrative simplification and electronic submission standardization. The HIPAA influences the way protected health information (PHI) is transferred and sets specific guidelines for protection of PHI used for treatment, payment and business operations.

On August 14, 2000, the DHHS issued a Final Rule for Standards for Electronic Transmissions as part of the Administrative Simplification portion of the HIPAA. Find the Final Rule at <http://aspe.hhs.gov/admsimp/final/txfin00.htm>. In October 2002, DHHS issued an addendum to the Final Rule, which was accepted in December 2002 and published in February 2003. This is the most current HIPAA compliant formatting standard for the Transaction Code Set (TCS) rule.

The OKMMIS follows the HIPAA mandated TCS standards as set forth by DHHS and CMS.



Chapter 8

Claims Resolution Process



INTRODUCTION

This chapter is designed to outline the process a claim goes through from submission to completion. By understanding this process, providers should have a better idea of how to evaluate their denied claims and how to get those claims corrected.

SECTION A: CLAIM CREATION

When paper claims are received, they are first sorted into groups related to the claim type (for example: outpatient, inpatient, dental, physician and crossovers).

Once the claims are sorted by claim type, the claims received are scanned into the Oklahoma Medicaid Management Information System (OKMMIS). The scanners translate the information into the OKMMIS by optical character recognition (OCR). This reduces the amount of human error by allowing the system to read the claims directly.

When claims are scanned into the OKMMIS, they are assigned an Internal Control Number (ICN). This number has information regarding the claim and assists the providers and the OHCA when researching a claim. An example of the ICN coding orientation is found below, followed by the coding description.

Coding orientation: R R Y Y J J J I I I I I

Code	Description
R R	These first two digits of the ICN refer to the region code assigned to a particular type of claim. Region codes are explained later in this chapter.
Y Y	These two digits of the ICN refer to the calendar year the claim was received. For example, all claims received in calendar year 2006 would have 06 in this field.
J J J	These three digits of the ICN refer to the Julian date the claim was received. Julian dates are shown on many calendars as days elapsed since January 1. There are 365 days in a year, 366 in a leap year, so a claim received on March 17, 2004, a leap year, would have a Julian date of 077, which indicates that March 17, 2004, is the 77 th day of 2004.
I I I I I I	The final six digits of the ICN refer to the claim number, which is assigned when the claim comes into the HPES mailroom.

Based on this information, an ICN number of 1006032123456 indicates that the claim was received on paper (region code 10), in the year 2006 (year 06), on February 1st (Julian date 032). The remaining 6 digits are assigned as a batch sequence number by the OKMMIS, and illustrate the order in which the claim was received.

Region codes indicate the claim submission method used. More frequently used region codes are:

Code	Description
10	Paper without attachments
11	Paper claims with attachments
20	Electronic claims with no attachments
21	Electronic claims with attachments
22	Internet claims with no attachments
23	Internet claims with attachments
25	Point of service claims
26	Point of service claims with attachments
40	Claims converted from old OKMMIS
45	Adjustments converted from old OKMMIS
47	Converted history-only adjustments
49	Recipient linking claims
50	Adjustments – non-check related
51	Adjustments – check related
52	Mass adjustments – non-check related
53	Mass adjustments – check related
54	Mass adjustments – void transactions
55	Mass adjustments – provider rates
56	Adjustments – void non-check related
57	Adjustments – void check related
58	Adjustments – processed by HPES SE
59	Provider reversals/voids
80	Claims reprocessed by HPES systems engineers
90	Special projects
91	Batches requiring manual review
92	HMO Co-pays
99	Converted claims with duplicate ICN

SECTION B: DATA ENTRY

Once claims are scanned into the OKMMIS and assigned an ICN, the OKMMIS sends the claim to the data entry department. There, the required fields are keyed manually to verify that the information necessary to process the claim is complete and accurate. Once the claim data are entered, the OKMMIS will attempt to automatically adjudicate the claim. The claim will run through two different types of edits. Please note that the following information regarding edits is very general, and should not be considered a full and comprehensive list of all the edits used by the OKMMIS system.

MMIS Edits

OKMMIS edits are wide-ranging edits that review the claim and details from a very general perspective. OKMMIS edits will review the claims data for accuracy, and compare the claim to the member's file to check for eligibility and programs. The system will then compare the claim to the provider's file for contract effective dates and check the provider's file to ensure that the provider type is eligible to receive payment for the type of services provided. Lastly, the system will check the service lines to ensure that the services being provided are covered under Oklahoma SoonerCare, as well as checking for any policy limitations regarding units allowed, prior authorizations or age restrictions.

ClaimCheck Edits

ClaimCheck edits evaluate claims for coding accuracy. ClaimCheck employs logic from three edits: Rebundling, Incidental, and Mutually Exclusive. The Rebundling edit checks are for procedure unbundling. This occurs when two or more procedure codes are used to report a service when a single and more comprehensive procedure code exists. Incidental edits check for certain procedures performed at the same time as a more complex primary procedure and are clinically integral to the successful outcome of the primary procedure. Mutually Exclusive edits check for procedures that represent overlapping services, or different techniques or approaches that accomplish the same result.

SECTION C: RESOLUTIONS

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system. The claim is paid, denied, suspended, or given a status of resubmit.

Paid Claims

Paid claims are claims that contain services which are covered by Oklahoma SoonerCare; however, they do not always result in a payment being issued. For example, if a claim is submitted which has a primary insurance payment of \$100.00, and a SoonerCare allowable of \$75.00, the claim will be marked paid, since the charges are eligible for coverage. No payment would be made under this circumstance. Additionally, if any lines on the claim are covered, the claim will be marked paid, even though one or more of the service lines may have denied.

Once a claim is assigned a paid status, the payment will be issued on the following financial cycle (usually on Wednesdays), and will be listed on the Paid Claims page of the provider's remittance advice (RA).

Denied Claims

Denied claims are claims that have been determined not covered by Oklahoma SoonerCare. These denials may be issued for various reasons including: non-covered services, inaccurate information submitted on the claim, member's eligibility or the provider's contract information.

Claims denied for non-covered service could be due to program restrictions or policy limitations. Providers can contact the OHCA call center for details on these denial types.

Claims denied for inaccurate information, including incorrect member's SoonerCare identification number, can be corrected by the provider and resubmitted for consideration.

Claims may be denied based on the member coverage being inactive for claim date(s) of service. Eligibility is determined by the Oklahoma Department of Human Services (OKDHS). Eligibility disputes should be directed to the member's local county OKDHS office.

In some instances, a claim may deny because of information listed on the provider's contract. The provider's contract period may have terminated or the provider's contract type may not be eligible to bill for the service provided (for example: a family practitioner billing for dental services).

Suspended Claims

Suspended claims are claims that are currently still in process. Claims suspend when they cannot be automatically adjudicated, or require additional review. Suspended claims are forwarded to a resolutions department for manual review. For example, if a claim has a primary insurance payment, the claim and attached documentation are reviewed. Remember, suspended claims are still being processed and do not need to be resubmitted.

Resubmit Status

Once a suspended claim has been reviewed, the resolutions department will resubmit the claim so the OKMMIS can rerun the editing process. The claims system cycles every six hours. Subsequently, a claim in resubmit status will normally adjudicate in no more than six hours. It is important to note that claims in resubmit status require no action from the provider.

Working Denied Claims

Claims can be denied at either the header or detail levels. The header level contains information about the member and provider, but not about the services performed. This is where the OKMMIS will verify member's eligibility and provider's contract information. Denials at this level will cause the entire claim to be denied.

The detail level of the claim contains information specific to the services performed. The detail level verifies coverage of services, policy limitations or program restrictions. Denials at this level will deny specific service lines and not the entire claim.

Once a claim has been denied, providers have two ways to research their denials: via the SoonerCare Provider Portal or the RA.

RA Research

When researching using the RA, locate the denied claims section. Once you have found a denied claim, view the header information. Any edits applying to the header information will be listed as Header EOBs. These codes are the HIPAA Adjustment Codes and contain general information about the claim. For further description of these codes, see the EOB Code Descriptions page of the RA. You may find several edits listed. Please note that not every edit listed is a denial edit. If there are no header denials, look at each detail line for edits specific to that service. These edits will be listed at the end of each detail line as Detail EOBs.

If the denial reason is still unclear, providers may contact the OHCA call center for assistance or log onto the SoonerCare Provider Portal at www.okhca.org and do additional research.

MOW Research

To research denied claims on the SoonerCare Provider Portal, go to the claim inquiry page. For information on how to get to this section, see the Web/RAS Usage chapter of this manual. On the claim inquiry screen, you may search by the denied ICN or the member ID and date of service. Once the claim has been accessed, scroll to the bottom of the claim to view the header and detail denials. The HIPAA Adjustment Code will be listed here along with a HIPAA Adjustment Remark Code, which provides more detailed information. If the denial reason is still unclear, you may select the HIPAA Adjustment Code number to view the MMIS EOB description. The MMIS EOB provides the most detailed information about the denial.

Once the reason for the denial has been determined, any inaccurate or incomplete information can be corrected and the claim can be resubmitted for processing. If all information is accurate and complete, the claim may have denied due to policy limitations or program restrictions.

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Chapter 9

Paid Claim Adjustment Procedures



INTRODUCTION

This section explains the business processes of how claim-specific adjustments and non-claim specific adjustments flow through the Oklahoma Medicaid Management Information System (OKMMIS). It is the responsibility of the adjustment department to process in a timely manner all claim-specific and non-claim-specific financial transactions. When a claim is adjusted, it is reprocessed as a new claim. When the adjustment claim processes, it may be affected by system changes made since the original claim was processed.

SECTION A: ADJUSTMENT CATEGORIES

Adjustments are classified in two categories – check-related (refund) or non-check related. Check-related adjustments are classified as either full or partial. An explanation of the claim adjustment types is provided below. Adjustments are made to paid detail lines only on paid claims.

Non-check Related Adjustment

Underpayment Adjustment

The provider is seeking additional reimbursement for a paid claim. The net payment to the provider is the difference between the original claim amount and the adjusted claim amount, when the adjusted claim amount is more than the original claim amount.

Overpayment Full Offset

The provider or the OHCA has recognized that a full overpayment for a claim occurred, and the provider or the OHCA has requested that the overpayment amount be deducted from future claim payments to the provider. After the adjustment void processes, the claim is systematically adjusted to zero and an account receivable is established for the entire amount of the claim.

Overpayment Partial Offset

The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider has requested that the overpayment amount be deducted from future claim payments. The historical data for the claim are adjusted and an account receivable is established for the overpayment amount.

Check Related Adjustment

Full Claim Refund

The provider or the OHCA has recognized that a full overpayment for a claim occurred and the provider issues a refund check for the amount of the entire claim payment. During the claim adjustment process, the refund amount is applied to the claim and the original claim is systematically adjusted to zero.

Partial Claim Refund

The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider issues a refund check for the amount of the overpayment. The refund amount is applied to the adjustment claim during processing and the historical data for the claim are adjusted.

Negative Adjustment Amounts (Overpayments)

If a claim is incorrectly adjudicated and the provider receives an overpayment, the provider is required to immediately take action with one of the following options:

- Mail a check in the amount of the overpayment along with a completed adjustment request form (HCA-14 for UB-04, and IP/OP Crossover or HCA-15 for CMS 1500, Dental and Crossover Part B). Please send check to:

OHCA – Finance

PO Box 18299
Oklahoma City, OK 73154

- Void the claim on the SoonerCare Provider Portal to setup a recoupment.

- Complete an adjustment request form (HCA-14 or HCA-15) and submit it according to the instructions on the form.

In addition, include: a copy of the paid remittance advice, and when applicable, a copy of the corrected claim; copy of the Medicare EOMB; and/or a copy of the insurance EOB. Please send correspondence to:

OHCA – Adjustment Unit

4345 N. Lincoln Blvd.
Oklahoma City, OK 73154-0299

If the payment is not received, recoupment procedures will be initiated by the OHCA.

When a claim has resulted in a recoupment, the amount of the overpayment will appear on your remittance advice as NET OVERPAYMENT (AR) and the amount of the overpayment will be listed. This amount will be deducted from the current remittance net payment. If the AR amount is larger than the net payment it will carry over to future remittances until satisfied. A summary of the recoupment activity is reported on the financial transactions page of the RA as well as the summary page.

Positive Adjustments (underpayments)

If a claim is incorrectly adjudicated and the provider receives an underpayment, the OHCA will initiate procedures to generate a payment adjustment to the submitted claim.

If the provider identifies an underpayment error to a paid claim, the provider may request a payment adjustment by submitting:

1. A completed adjustment request form (HCA-14 for UB, Inpatient/Outpatient crossover, or HCA-15 for 1500, Dental or Crossover Part B) for each claim requested for adjustment.
2. A copy of the paid RA or detailed explanation of the paid information and a copy of the corrected claim. If applicable, a copy of the Medicare EOMB and/or copy of the insurance EOB.
3. Any additional documentation – including sterilization consent form, the hysterectomy acknowledgment, abortion certification or patient certification for Medicaid funded abortion. These documents must be attached to the adjustment request

in order to assist the OHCA in making proper determination

All documentation is mailed to:

OHCA – Adjustment Unit
4345 N. Lincoln Blvd.
Oklahoma City, OK 73154-0299

OHCA Review

Each adjustment request is reviewed for proper documentation and OHCA policy and procedural compliance. Requests failing to meet these requirements will be returned to the provider for the missing information.

SECTION B: ADJUSTMENT TYPES AND WORKFLOW

Adjustments are typically initiated by the provider but may also be requested by the OHCA. The provider completes an adjustment request form and forwards it to the specified adjustment address on the form.

Non-check-Related Adjustment (regions 50 and 56)

Non-check-related adjustments are defined as provider requests for additional payment, which are referred to as:

1. An underpayment adjustment, or
2. Provider requests for an overpayment amount to be deducted from future claim payments (referred to as an offset adjustment).

Offset adjustments are further categorized as full-claim offsets or partial-claim offsets. Non-check-related adjustments are processed through the OKMMIS.

Check-Related Adjustment (regions 51 and 57)

Check-related-adjustment requests are cash receipts received and dispositioned as claim-specific refunds to the OHCA. The refunded dollar amount is posted to the specific claim as the adjustment is processed in the OKMMIS. A reason code, that indicates the source of the refund, is typed in the adjustment record. This allows the system to categorize the refunds into provider, SURS and TPL recoveries for cash management reporting. Check related adjustments are processed through the OKMMIS.



Chapter 10

Indian Health Services



INTRODUCTION

In Oklahoma there are three types of Indian Health facilities: Indian Health Service (IHS), Tribes and Urban Indian clinics. IHS is the federal agency responsible for providing health services to most American Indians and Alaska natives. Unlike SoonerCare, IHS is not an entitlement program. Instead, this provision of health care to American Indians and Alaska natives falls under the federal trust responsibility that recognizes the debt owed to Indian tribal governments. Eligibility for care at IHS, Urban Indian and Tribal facilities is usually determined under federal statute and regulation, and depends largely (but not exclusively) on membership in a federally recognized tribe.

SECTION A: SOONERCARE ELIGIBILITY

As a matter of law, American Indians who meet SoonerCare eligibility standards are entitled to SoonerCare coverage. This applies to American Indians as it does to other American citizens. SoonerCare reimburses Indian Health providers for covered services provided to American Indian SoonerCare members. Indian Health is always the payer of last resort when an American Indian SoonerCare member is eligible for services through multiple payers such as Medicare, Medicaid and Indian Health.

SECTION B: CONTRACT HEALTH SERVICES

Most IHS, Tribal and Urban Indian facilities provide basic health care services. When specialty services are needed, an Indian Health facility may authorize payment for contract health services. Contract health services are defined by IHS as “services not available directly from IHS or tribes that are purchased under contract from community hospitals and practitioners.” It is important to note that contract health services are usually purchased through a prior authorization arrangement. Since Indian Health is not an insurance company, it is not obligated to pay for health care services unauthorized by the facility.



Chapter 11 Pharmacy



INTRODUCTION

The purpose of the pharmacy division is to manage the Medicaid Pharmacy program in the most efficient and comprehensive manner possible by researching, designing and implementing mechanisms to ensure appropriate, cost effective and quality therapy.

Pharmacy Policy (Rules)

Here is a brief overview of Pharmacy rules*:

- Dispensing limitation: 34 day supply or if on maintenance list up to 100 units.
- Covered Drugs: Must have a Federal Drug Rebate Agreement.
- Excluded Categories: Fertility, cosmetic, weight loss/gain, nutritional supplements.
- Reimbursement - Use the lower of
 - Ingredient cost
 - AWP -12%
 - WAC +5.6%
 - SMAC/FUL
 - Pharmacy's Usual & Customary Cost.
- Dispensing Fee – \$3.71.
- Copays:

There will be a \$4.00 co-pay for most SoonerCare members.

For SoonerCare members in home and community-based waiver programs the co-pays are as follows;

- Zero on Preferred generics
- \$0.65 for \$0.01 to \$10.00
- \$1.20 for \$10.01 to \$25.00
- \$2.40 for \$25.01 to \$50.00
- \$3.50 for \$50.01 and greater
- Copayment is not required of
 - a. members younger than 21 years old;

- b. members in nursing facilities and intermediate care facilities for the mentally retarded; or
- c. pregnant women.

- o Copayment is not required for family planning services. Includes all contraceptives and services rendered.

*Pharmacy program rules change frequently. For the most up-to-date SoonerCare Pharmacy program rules, visit the OHCA Web site at www.okhca.org/rx.

Prescription Drug Benefit

- Six RXes per month with two brand name drug limit.
- RXes that don't count toward prescription limit are HIV antiretrovirals, Chemo, contraceptives.
- Long Term Care – no limit.
- Members under 21 - no limit.
- Waiver Advantage members.
 - o Seven extra generics, plus Therapy Management if additional prescriptions are needed.

Product Based Prior Authorization (PBPA)

This program divides certain therapeutic categories of drugs into two or more levels called Tiers. Tier 1 medications are preferred as the first step for treating a member's health condition. They are cost effective and in most cases available without prior authorization (PA) from the OHCA. Members who do not achieve a clinical success with Tier 1 medications may obtain a Tier 2 or greater medication with a PA. Providers that have members with clinical exceptions may request a PA to skip the step therapy process and immediately receive Tier 2 or greater. For more information, please review the OHCA Web site at www.okhca.org/providers/rx/pa.

Durable Medical Equipment (DME)

The general guidelines concerning the documentation necessary to obtain a prior authorization for DME supplies is located at www.okhca.org/providers/dme/paguidelines. Please be sure that you use your DME provider number, not your pharmacy provider number, when billing DME claims. DME claims will not process through the pharmacy point-of-sale system. For a list of providers that are willing to bill for DME supplies, go to www.okhca.org/providers/dme/dmeproviders. If you are not a

contracted DME provider and would like to be, please contact provider contracts at 800-522-0114, opt. 5, or download, complete, and return the contract forms to www.okhca.org/providers/enrollment/dme-msc.

Pharmacy Lock-In Program

When it is decided that a member meets specific criteria and should be placed in the Lock-in program, a pharmacy is assigned to that member and their eligibility file is updated to only pay claims at that pharmacy. Referrals are made to the Lock-In unit by several sources. These include: physicians, pharmacies, caseworkers and OHCA staff. Referrals can be made by phone, online or in writing.

Lock-In Decision Process

Once a member is referred to the Lock-in program, the following information is verified and reviewed for each case.

1. Eligibility (members that are not eligible are not reviewed).
2. Medicare eligibility. (not reviewed if eligible)
3. Paid pharmacy claims for past year.
4. Hospital claims for past year.
5. History of diagnostic information.
6. Number of prescribers and their specialties.

The lock-in process is started if the review shows that the member meets the required criteria based on this information.

Cases that look questionable but do not fully meet the criteria generally result in the monitoring of members or a warning letter sent to members. Warning letters are sent to members explaining that they are being monitored due to a high number of visits to different pharmacies. Cases that receive warnings are reviewed again in six months. If there is no improvement, the members are entered into the Lock-in program. If the behavior improves, the cases are closed. If a decision is made to monitor without a warning, the case is reviewed again in three months and a new decision is made based on behavior pattern.

Safety Concerns Criteria List

- Number of ER visits (3).

- Number of different pharmacies (3).
- Number of different prescribers/physicians (5) (combined).
- Number of days supply of controlled substances.
- Diagnosis of drug dependency/ other diagnosis.
- Number of hospital discharges (3).
- Other information from past reviews.

Who To Call

- -OHCA *Main number* - 800-522-0114 or 405-522-6205
- -Pharmacy Help Desk, Opt 4 - Mon-Fri (8:30a – 7:00p),
Saturday (9:00 am-5:00 pm) and Sunday (11:00 am-5:00 pm)

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Chapter 12

Insure Oklahoma



INTRODUCTION

Insure Oklahoma was founded in 2005 in an effort to help provide health coverage to uninsured, working Oklahomans.

Insure Oklahoma is a program under the SoonerCare umbrella and administered by the Oklahoma Health Care Authority (OHCA). This program consists of two benefits branches.

First is the Insure Oklahoma Employer Sponsored Insurance (ESI) program geared to small businesses. This program offers premium subsidy assistance for qualified group health care plans to eligible employees.

The second is Insure Oklahoma Individual Plan (IP), which is designed as an option for people who cannot access Insure Oklahoma through their employer.

Member eligibility for both programs requires candidates to:

- Have a household income not exceeding 200 percent of the federal poverty level (FPL)
- Have valid Oklahoma residency
- Be a U.S. citizenship or a legal alien not currently receiving Medicaid or Medicare services
- Be 19 to 64 years old.

SECTION A: WHAT IS THE INSURE OKLAHOMA INDIVIDUAL PLAN?

Insure Oklahoma is operated by the OHCA. An Insure Oklahoma Individual Plan member must choose an Insure Oklahoma Primary Care provider for themselves, and if eligible, their spouse and/or dependents.

This plan provides coverage to eligible:

- Self-employed individuals
- Workers who cannot access Insure Oklahoma through their employer
- Workers who have a disability with a ticket to work
- Unemployed individuals currently eligible for Oklahoma unemployment

Questions about benefits or the plan in general should be directed from Monday through Friday, 8 am to 5 pm, to the Insure Oklahoma Helpline at 888-365-3752 or TDD at 405-416-6848.

Persons Ineligible for the Insure Oklahoma Individual Plan

Certain persons are ineligible for Insure Oklahoma even though they may be eligible under other portions of the SoonerCare program. These Exempt persons will not be enrolled in Insure Oklahoma if they are: a dependent 18 years old or younger or eligible for Medicare or Medicaid, including SoonerCare Choice.

Coverage for Children

Children are eligible for Insure Oklahoma if household income is between 186-200% of the federal poverty level. If the household income is less than 185% children may qualify for health care coverage through SoonerCare Choice. Call 405-521-3646 for more information.

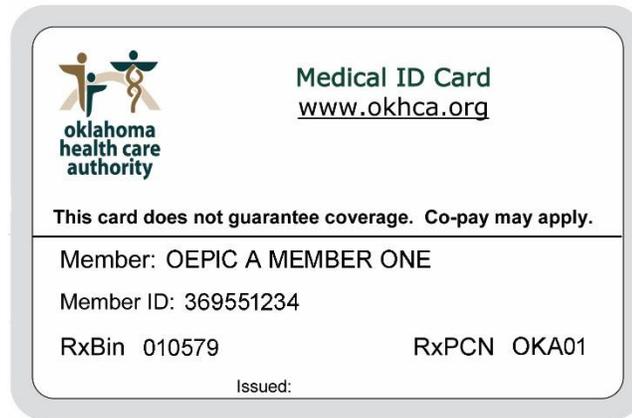
Medical ID Card

Insure Oklahoma medical ID cards may look the same or different than SoonerCare cards. Both card versions may be valid.

See examples below:



Old Version



New Version

Important Phone Numbers

Emergency Services

Call 911 or go to the nearest emergency room. Call your medical provider as soon as possible. Do not use the emergency room for urgent care. Urgent care is when you get sick or hurt and there is no immediate danger. Call your medical provider for urgent care.

Provider Eligibility

Only claims from OHCA-contracted providers will be considered for payment. This card does not guarantee eligibility or payment for services. To confirm eligibility, call the nationwide toll-free number at 800-767-3949 and in metro Oklahoma City at 405-840-0650 or access the SoonerCare Provider Portal at: www.okhca.org.

Members

For general information, call the Insure Oklahoma Helpline at 888-365-3742. For TDD Line, call 405-416-6848. For the Patient Advice Line, call 800-530-3002.

SECTION B: INSURE OKLAHOMA INDIVIDUAL PLAN BILLING PROCEDURES

The billing procedures for the Insure Oklahoma IP are the same as the SoonerCare billing procedures. Please refer to the Claim

Completion chapter of this manual for details. The Insure Oklahoma IP uses the same mailing addresses as SoonerCare.

Claims are subject to a co-payment. The provider reimbursement will be based on the Medicaid allowable plus the co-payment. Providers who choose to be primary care physicians will be eligible to be chosen by members. Primary care referrals will follow the same guidelines as they do with SoonerCare.

PCP Payments

Insure Oklahoma PCPs will get a \$3 monthly case-management fee per recipient.

Changes to Primary Care Physician panels

If the provider's panel is closed, yet there is a patient the provider is willing to add to its panel, the Provider Action form (SC-13) will need to be completed and faxed to 405-917-7374.

Eligibility

Checking eligibility for IP will follow the same process as SoonerCare. A magnetic strip on the back of the card is used by the swipe machines to read member information. Eligibility is also accessible on the Web or through the Automated Voice Response (AVR) system. When viewing eligibility, the system will reflect the program for Public Product (PUB), for those enrolled in the IP.

Prior Authorization

The OHCA handles the IP Prior Authorization (PA) process.

Adjustments

Adjustments for the IP guidelines are the same as SoonerCare's.

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Chapter 13

Long Term Care Nursing Facilities



INTRODUCTION

SoonerCare provides members with coverage for long-term care (LTC) nursing facilities and Intermediate Care Facilities for the mentally retarded (ICF-MR). SoonerCare reimburses providers with a set lump-sum payment for each member under their care. Items covered by the reimbursement include: dietary needs, room and board, personal hygiene items and most over-the-counter drugs.

SECTION A: LTC NURSING FACILITY PROVIDER ELIGIBILITY

Long-Term Care (LTC) Nursing Facilities may receive payment for the provision of nursing care under the SoonerCare Title XIX program only when they are properly licensed and certified by the Oklahoma Department of Health, meet federal and state requirements, and hold a valid written agreement with the Oklahoma Health Care Authority (OHCA).

To obtain additional information, go to www.okhca.org, select the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

SECTION B: PRE-ADMISSION SCREENING AND RESIDENT REVIEW PROCESS (PASRR)

Federal law requires that all members entering SoonerCare certified nursing facilities must be screened for possible mental illness, mental retardation or related conditions prior to admission. Nursing facilities are required to complete form LTC-300R for all members entering the facility, regardless of pay source. Providers may also submit the LTC-300R electronically using the OHCA SoonerCare Provider Portal. For additional information, go to www.okhca.org, select the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

SECTION C: ICF/MR PROCESS

Pre-approval and final approval for medical eligibility of SoonerCare certified members entering public and private ICF/MR are made by the Level of Care Evaluation Unit at the OHCA. ICF/MR facilities are required to complete form LTC-300 as well as provide evidence of mental retardation or related condition and additional documentation of active treatment needs. For additional information, go to www.okhca.org, select the Provider link, select the OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

SECTION D: MEMBER LEVEL OF CARE APPEALS PROCESS

By law, any member who feels adversely affected by any preadmission screening and resident review (PASRR) determination made by the OHCA regarding a preadmission screening or an annual resident review may request a fair hearing within 30 days from the date of notice of the PASRR result. The member or authorized agent may contact the county DHS office to request a fair hearing Form H-1 to initiate the appeals process.

Providers or physicians who would like to appeal a level-of-care decision may request the OHCA form LD-2 by contacting the OHCA Grievance Docket Clerk Legal Division at 405-522-7217

For additional information on documentation standards, go to www.okhca.org, select the Provider link, select the OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

SECTION E: BILLING CONSIDERATIONS

Individuals requesting billing information regarding nursing facilities should refer to the Electronic Data Interchange and Billing Instructions chapters of this manual. Nursing facilities will use the UB 92 paper form, 837-I for electronic batch submission and/or Direct Data Entry through the OHCA SoonerCare Provider Portal for claim submission. Verifying the member's eligibility and program eligibility is very important. Members in nursing facilities are excluded from enrollment in SoonerCare Choice. If a member is enrolled in SoonerCare Choice, they must be disenrolled from managed care after admission to a nursing facility or ICF-MR.

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Chapter 14

Third Party Liability



INTRODUCTION

Private insurance coverage generally does not exclude an individual from receiving Oklahoma Health Care Authority (OHCA) benefits. Many OHCA members have other insurance in addition to the OHCA. Insurance may be a commercial group plan through the member's employer, an individually purchased plan, Medicare, or insurance available as a result of an accident or injury. For most Oklahoma members, the OHCA supplements other available coverages and is primarily responsible for paying the uncovered medical expenses.

To ensure that the OHCA does not pay expenses covered by other sources, federal regulation (*42 CFR 433.139*) established the OHCA as the payer of last resort. This means that if an OHCA member has any other resource available to help pay for the cost of his or her medical care, that resource must be used prior to the OHCA. Other resources include, but are not limited to

- Commercial health insurance policies, both group and individual
- Medicare
- TRICARE, formerly known as CHAMPUS
- Indemnity policies that pay a fixed per diem for hospital or nursing home services
- Auto insurance
- Homeowner's insurance
- Worker's compensation
- Other liability insurance

In Oklahoma, the Victim Compensation Act and Indian Health Services are the only resources that do not have to be used prior to the OHCA.

OHCA Third Party Liability Program

The OHCA Third Party Liability (TPL) program is charged with ensuring compliance with federal and state TPL regulations. The program has two primary responsibilities:

1. To identify OHCA members who have third party resources available.
2. To ensure that those resources pay prior to the OHCA.

The OHCA has full authority to fulfill these responsibilities. The OHCA member must sign an assignment of rights form, which

allows the third party payment be made directly to the OHCA. This is one of the eligibility conditions to OHCA membership. Each member must further agree to cooperate with the OHCA to obtain payment from those resources, including authorization of providers and insurers to release necessary information to pursue third party payment. TPL requirements are the same, regardless of the type of third party resource. The TPL program fulfills its responsibilities based on whether the other resource falls under the general category of health insurance. These may include: commercial policies, Medicare, and liability insurance such as auto and homeowner.

The TPL program has four primary sources of information for identifying members who have other health insurance: caseworkers, providers, data matches and discrepancy letters.

Caseworkers

When a member applies for SoonerCare, the caseworker asks if the member has other insurance coverage. If so, the caseworker obtains all available information about the other policy and updates the member's file, which will update the OKMMIS with that information.

Providers

During the OHCA member's medical appointment, providers must ask if the member has other insurance coverage. If so, the provider obtains information about the other policy and provides it to the OHCA by written notice, phone call or inclusion on a claim form. Providers should request that the OHCA member sign an assignment of benefits authorization form. This form should state that the member authorizes the insurance carrier to reimburse the provider directly.

Data matches

The OHCA uses private vendors, Health Management Systems (HMS) and HP Enterprise Services (HPES) to perform regular data matches between OHCA members and commercial insurance eligibility files. Data matches are performed with all major insurers, including Blue Cross and Blue Shield, Aetna, Cigna, HealthChoice and others.

Discrepancy Letter

The discrepancy letter is used to update the OHCA member's file. This letter will be mailed to a provider when there is a TPL payment indicated on a paid claim, but no TPL is shown in the

HPES system. The completed discrepancy letter can be faxed or mailed to the TPL unit. The unit verifies the information prior to updating the system. This form can be downloaded from the OHCA Web site. It is located in the Forms section under TPL forms. Regardless of the source, all TPL coverage information is stored in the HPES system and available to providers through the Eligibility Verification System (EVS).

SECTION A: SERVICES EXEMPT FROM THIRD PARTY

Liability/ Cost Avoidance Requirements

To increase overall savings to the OHCA, the Centers for Medicare and SoonerCare Services (CMS) encourage three types of medical services:

1. Pregnancy care.
2. Prenatal care.
3. Preventive pediatric care, including Early Periodic Screening Diagnosis and Testing (EPSDT)

To help ensure that providers are not deterred from providing these services, federal regulations exempt claims for these types of care from the cost-avoidance requirement. Providers that render any of these exempted services are still permitted, but are not required, to bill available third party resources. Claims for these services, identified by the diagnosis codes, bypass the normal cost-avoidance process.

Cost Avoidance

When a provider determines that a member has an available TPL resource, the provider is required to bill that resource prior to billing the OHCA. If the EVS indicates TPL resource information and the provider submits a claim to the OHCA without documentation that the third party resource was billed, federal regulations (with a few exceptions as described in Section B of this chapter) require that the claim be denied. This process is known as cost avoidance. When a claim is cost avoided, the provider must bill the appropriate third party. If that resource denies payment or pays less than the OHCA would have paid, the provider can rebill the OHCA. Providers must be fully aware of and comply with the procedures outlined in this chapter to prevent claims from being erroneously cost avoided.

Liability Insurance

Unlike health insurance, liability insurance is generally available only under certain circumstances. For example, an auto insurance liability policy covers medical expenses only if expenses are the direct result of an auto crash and the policy's insured is liable. However, if there is medical payments coverage under the auto policy of the vehicle in which the member was injured, the member must only establish that the injuries are accident-related. He or she does not have to establish liability to pursue a medical payments' claim. Under homeowner's and other property-based liability insurances, the at-fault party's liability generally must be established before an injured member is reimbursed for medical expenses related to the injury, unless there is a separate medical payments coverage available under the policy. In that case, to obtain medical payment benefits, the member would typically only have to establish they were injured on the property. Because of the circumstantial nature of this coverage, the OHCA does not cost avoid claims based on liability insurance.

If a provider is aware that a member has been in an accident, the provider can bill the OHCA or pursue payment from the liable party. If the OHCA is billed, the provider must note that claims are for accident-related services by marking the appropriate box in field 10 on form 1500, listing the appropriate occurrence code on form UB-04; or entering the appropriate Related Causes Code in data element 1362 on form 837 Professional (837P) or 837 Institutional (837I) electronic transaction. Providers that choose to initially pursue payment from the liable third party must remember that claims submitted to the OHCA after the one-year timely filing limit are denied.

When the OHCA pays claims for accident-related services, the TPL program performs post-payment research, based on trauma diagnosis codes, to identify cases with potential liable third parties. When third parties are identified, the OHCA presents all paid claims associated with the accident to the responsible third party for reimbursement. Providers are not normally involved in this post-payment process, and are not usually aware that the OHCA has pursued recoveries. Providers may contact the TPL unit with questions about TPL case procedures and are encouraged to report all identified third party liability cases to the TPL unit. For example, if a provider receives a record's request from an attorney regarding a third party liability case, providers are encouraged to notify the TPL unit of these requests.

SECTION B: THIRD PARTY LIABILITY CLAIM PROCESSING REQUIREMENTS

This section outlines provider responsibilities for supporting cost containment through timely identification and billing of primary insurers. Providers are required to bill all other insurance carriers prior to billing the OHCA, except for programs that are secondary to the OHCA. The TPL Unit is available to assist with determining other insurance resources and maintaining the most current member TPL files.

Documentation Requirements

The OHCA must deny claims if there is evidence that TPL exists and documentation indicating that the third party was billed is not submitted with the claim. To prevent claims from being denied, providers must be aware of responsibilities concerning third parties and comply with the procedures described in this chapter.

Third Party Liability Identification

Prior to rendering a service, the provider must verify that the member is eligible. Use the EVS described in the Member Eligibility chapter of this manual to check eligibility status for all members. Additionally, the EVS should be used to verify TPL information so providers can determine if another insurer is liable for all or part of the bill. EVS has the member's most current TPL information, including, the insurance carrier, benefit coverage and policy numbers. In some cases, it is not possible to determine by the EVS if a specific service is covered. If a specific service does not appear to be covered by the stated TPL resource, providers must still bill that resource to receive a possible denial or payment. For example, some insurance carriers cover optical and vision services under a medical or major medical plan. Medical services that are covered by a primary insurer must be billed first to the primary insurer. If there is no other insurer indicated on the EVS and the member reports no additional coverage, bill the service to the OHCA as the primary payer.

When the EVS shows a member is a qualified Medicare beneficiary (QMB) only or a specified low income Medicare beneficiary (SLMB) only, the provider should contact Medicare to confirm medical coverage. Failure to confirm medical coverage with Medicare could result in claim denial because the Medicare benefits may have been discontinued or recently denied. The OHCA pays the Medicare premiums for SLMB only and QMB only members, but does not provide medical coverage. The

coinsurance and deductible are covered for members with Medicare entitlement.

Prior Authorization

A service requiring OHCA's prior authorization (PA) must be satisfied to receive payment from the OHCA, even if a third party paid a portion of the charge. The only exception is when the third party payer is Medicare Parts A or B and Medicare allows in whole or in part for the service.

Billing Procedures

When submitting all claims, the amount paid by a third party must be entered in the appropriate field on the claim form or electronic transaction, even if the payment amount is zero (\$0).

If a third party payer made payment, an explanation of payment (EOP), explanation of benefits (EOB), or remittance advice (RA) is not required for electronically submitted claims.

When a member has other insurance and the primary insurer denies payment for any reason, a copy of the denial such as an EOP, EOB or RA must be attached to the OHCA claim or the claim will be denied.

If an EOP, EOB or RA cannot be obtained, attach to the claim a statement copy or correspondence from the third party carrier.

When billing the OHCA for the difference between the amount billed and the primary insurer's payment, the OHCA pays the provider the difference, up to the OHCA allowable charge. If the primary insurer payment is equal to or greater than the allowable charge, no payment is made by the OHCA. In this instance, the provider is not required to send the claim to the OHCA for processing. Providers cannot bill members for any balance.

Non-Covered Services or Lifetime Maximum Exceeded

When a service that is repeatedly furnished to a member and repeatedly billed to the OHCA is not covered by the third party insurance policy, a provider can submit photocopies of the original denial for up to one year from the date of the original denial. The provider should write Non-Covered Service on the insurance denial when submitting copies for billing purposes. For example, if an insurer denies a claim for skilled nursing care because the policy limits are exhausted for the calendar year, that same denial could be used for subsequent skilled nursing care related claims for the duration of that calendar year. The denial reason must relate to the specific services and timeframes of the new claim.

Subsequent Third Party Liability Payment

TPL payments received by providers for claims paid by the OHCA cannot be used to supplement the OHCA allowable charges. If the OHCA paid the provider for services rendered and the provider subsequently receives payment from any other source for the same services, the OHCA payment must be refunded within 30 days. The refund should not exceed the OHCA payment to the provider. Checks must be made payable to the OHCA and mailed to:

OHCA Finance Unit
PO Box 18299
Oklahoma City, OK 73154

Remittance Advice Information

If a claim denies for TPL reasons, Electronic RAs identify this information with the adjustment reason and adjustment remark codes. If the provider has information that corrects or updates the TPL information provided on the RA, follow the procedures for updating TPL information. For additional information, refer to the Member Third Party Liability Update Procedures section in this chapter.

Insurance Carrier Reimburses OHCA Member

Providers with proof that an OHCA member received reimbursement from an insurance carrier should follow these steps:

1. Contact the insurance carrier and advise them that payment was made to the member in error. Request that a correction and reimbursement be made to the provider.
2. If unsuccessful, the provider must bill the member for the services. In future visits with the OHCA member, the provider should request that the OHCA member sign an assignment of benefits authorization form. The form states the member authorizes the insurance carrier to reimburse the provider. This process might result in reimbursement to the provider.

SECTION C: COORDINATION WITH COMMERCIAL PLANS

Specific guidelines must be followed to receive payment from the OHCA when submitting claims for a member enrolled in private preferred provider organization (PPO) or private health maintenance organization (HMO) plans.

HMO Billing OHCA

The OHCA reimburses providers for co-payments and services not covered by commercial plans incurred by OHCA members under a capped arrangement.

Co-payment Billing

In 2001, the OHCA implemented a procedure for providers to bill the OHCA for HMO co-pays on eligible SoonerCare recipients enrolled in private health plans and Medicare Replacement HMOs.

The appropriate claim form (UB-04 or 1500) should be used. At the top of the claim form, print in large letters: "HMO co-pay." Use the appropriate procedure code. However, provide only the desired co-pay reimbursement amount due in box 24F and 29 on the 1500 claim form and box 47, the TOTALs box, and box 55B on the UB-04.

Only paper claims will be accepted for HMO co-pays and all other blocks on the UB-04 or 1500 should be completed according to your provider manual.

The claim forms should be mailed to:

HP Enterprise Services

P.O. Box 18500

Oklahoma City, OK 73154

Claims will be subject to all other applicable regulations. If you have any questions, please call the OHCA at 405-522-6205 or 800-522-0114.

Covered And Non-covered Services Billing

When billing for services not covered under the member's plan, the provider bills the OHCA and indicates carrier denied in the TPL amount on forms 1500 or 837P. The provider must attach a copy of the statement from the capped plan that indicates the service is not covered. The OHCA requires that a member follow the rules of his or her primary insurance carrier. Therefore, if the primary insurance carrier requires the member to be seen by in-network providers only or payment will be denied, the OHCA does not reimburse for claims denied by the primary carrier because the member received out-of-network services. However, if the primary carrier pays for out-of-network services at the same rate as in-network services or at a reduced rate, the provider may submit the bill to the OHCA. Also, if the primary insurance carrier pays for out-of-network services, but does not pay a particular bill in full due to a deductible or co-payment, the provider may still submit the bill to the OHCA. If no payment or a partial payment

was made by the primary carrier, this should be indicated on the claim form, and documentation from the carrier noting the deductible or co-payment amount must be attached to the claim.

SECTION D: MEDICARE-OHCA RELATED REIMBURSEMENT

Many OHCA members are eligible for SoonerCare and Medicare. These individuals are called dually eligible. According to TPL regulations, Medicare is treated just as any other available resource. Thus, when an OHCA member is also enrolled in Medicare, providers must bill Medicare prior to submitting a claim to the OHCA for reimbursement. For an OHCA provider to receive reimbursement from Medicare, the provider must be enrolled in the Medicare program. Providers can be enrolled in Medicare as participating or nonparticipating. Medicare participating providers receive payment directly from Medicare. Medicare benefits for nonparticipating providers are paid directly to the OHCA member.

In either scenario, the OHCA pays the co-insurance and deductibles. If a provider is not enrolled in Medicare, either as participating or nonparticipating, the member should be referred to a Medicare/SoonerCare dually enrolled provider. OHCA reimbursement is not available to a non-Medicare enrolled OHCA provider who renders service to a Medicare/SoonerCare dually eligible member.

Medicare Enrolled Participating Provider Reimbursement Process

When a provider is enrolled with Medicare, the Medicare payment is made directly to the provider. The provider accepts Medicare's allowable amount and the patient is not responsible for the disallowed amount. The OHCA is only responsible for the deductible and coinsurance. For example, the charge is \$150, the allowable amount is \$100, \$50 is disallowed, the deductible is \$25 and coinsurance is \$15. Medicare pays \$60; the provider absorbs \$50. The OHCA pays \$40. The member is not responsible for any charges

Medicare Enrolled Non-participating Provider Reimbursement Process

When a nonparticipating provider is enrolled with Medicare, the Medicare payment is made to the member. The member is responsible for the complete charge, as the provider does not accept assignment. For example, the charge is \$150, the allowable amount is \$100, the disallowed amount is \$50, the deductible is \$25 and the coinsurance is \$15. The patient is billed for \$150.

Medicare reimburses the patient \$60 and the patient is responsible for paying the remaining \$50.

The OHCA SoonerCare member must be referred to a Medicare/OHCA SoonerCare provider to receive the best benefit.

Crossover Claims

It is important to remember that providers must include the correct Medicare identification number for a claim to crossover automatically. The following information concerns crossover claims:

- If a provider does not receive the OHCA payment within 60 days of the Medicare payment, claims that did not crossover should be submitted to the crossover processing address.
- If the member has a Medicare supplement policy, proof of filing with the Medicare supplement carrier as well as Medicare must be submitted with the OHCA claim or the claim will deny.
- If the member has a Medicare supplement policy, the claim is filed with Medicare and automatically crosses over to the Medicare supplement carrier rather than the OHCA for payment of coinsurance and deductible. After the provider receives all EOBs, the provider must submit the claim and EOBs on paper to the OHCA.

NOTE: If the TPL benefit code has been entered incorrectly as a hospitalization (A) or medical (C) versus Medicare Supplemental Part A (O) or Medicare Supplemental Part B (P) for the supplemental policy, the claim crosses directly to the OHCA and may be paid without proof of filing with the Medicare supplement carrier. These situations generally result in OHCA overpayments that must be refunded immediately. To prevent overpayment, a provider that identifies enrollees with a Medicare supplemental policy conveyed as an A or B on EVS can request a TPL file update by sending a copy of the enrollee's Medicare supplemental insurance card to the TPL Unit.

Providers whose claims are not crossing over automatically should contact Provider Enrollment to verify that OHCA has your Medicare provider number correctly in the system.

Prior Authorization

Prior authorization is not required for members with Medicare Part A and Part B coverage if the services are covered by Medicare and Medicare pays for the services in whole or in part. Services not

covered by Medicare are subject to normal prior OHCA authorization requirement restrictions, referral and prior authorization requirements of SoonerCare.

Medicare Non-Covered or Denied Services

Claims for services not covered by Medicare will crossover to OHCA and be denied. The claim must be resubmitted to the OHCA's PO Box 18506, Oklahoma City, OK 73154 address, with a copy of the Medicare RA and the HCA-17 form attached. These claims are treated as any other TPL claim. Certain services are excluded and never covered by Medicare; therefore, the OHCA can be billed first for these services, bypassing the requirement to bill Medicare first. This applies to Medicare supplements as well. Otherwise, OHCA benefits can only be paid to the provider of services after Medicare payment or denial of payment occurs.

Other Third Party Liability Resources

If the member has other insurance on file that covers those services not covered by Medicare, the other insurance resources must be billed before the OHCA.

SECTION E: MEMBER THIRD PARTY LIABILITY UPDATE PROCEDURES

Other insurance information is entered into the DHS system by the caseworker when a member is enrolled in the OHCA. The information is transmitted electronically via real-time transaction to the OHCA. The county office and the OHCA TPL Unit update TPL information. The TPL Unit is the primary entity for maintaining TPL information about the member. Providers who receive information about OHCA members from insurance carriers that is different from what is listed on EVS can forward the information to the TPL Unit. Information about additional insurance coverage or changes in insurance coverage must be relayed to the TPL Unit as soon as possible to keep member files current and to assist in accurate provider claim processing.

Automated Recovery, Resource Data Request Letters and Questionnaires

Automated discrepancy letters and questionnaires are sent to insurance carriers, members, and providers when recoveries are initiated or TPL resource data are requested. When the TPL data are verified, the system is updated accordingly. As a result, providers have access to the most current insurance billing

information through the eligibility verification system (EVS) applications or the automated voice response (AVR) system. When a discrepancy letter is received, providers must thoroughly complete the form and return it to the TPL Unit via fax or mail. The address is indicated on the form.

Providers may access and use the discrepancy letter, and TPL Accident/Injury Questionnaire on the OHCA Web site. When a questionnaire is completed, the provider can fax or mail it to the HPES TPL Unit. The TPL Unit verifies and investigates the information prior to updating the system.

General Update Procedures

When forwarding update information to the TPL Unit, indicate the member identification (RID) number and any other pertinent member or carrier data on all correspondence. Copies of letters, RA, EOB or EOP information from other insurance carriers are important for maintaining member TPL file information. Carrier letters, RAs, EOPs or EOBs that document coverage must substantiate any requested changes. Mail the above information concerning other insurance coverage to:

TPL Unit

Third Party Liability Update
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

The TPL discrepancy letter can be downloaded from the OHCA Web site. When completed, providers should fax or mail it to the address indicated on the letter.

The TPL Unit can be reached by phone at 800-522-0114 and selecting option 3 then 2.

The TPL Unit reviews and verifies the OHCA member insurance information, coordinates with the carrier, if required, and makes necessary changes to the TPL file in the OHCA system to accurately reflect member TPL coverage. Providers can confirm the update with EVS or by calling the TPL Unit. Allow 10 business days from the date of receipt for the OHCA member's file to be updated.

Telephone Inquiry Procedures

To discuss other insurance issues, providers should contact the TPL Unit using the telephone numbers below from 8 a.m. to 5 p.m. Monday through Friday, excluding holidays:

Third Party Liability Unit
800-522-0114 *Option 3, 2*

Fax: 405-530-3478

When calling the TPL Unit, have the member's identification number available. This telephone inquiry function is limited to TPL issues. Direct general provider inquiries to the OHCA Call Center.

NOTE: *OHCA cannot provide information about benefits covered under each coverage type. Providers should contact the insurance carrier for this information.*

Written Inquiry Procedures

Documentation must substantiate each change made to a member's TPL file. If changes to member files are necessary, providers must forward copies of information from other insurers that document the member's TPL information to be updated.

When forwarding update information to the TPL Unit, indicate the member's name; RID number; copy of EOB, RA, member's third party insurance card, letter from carrier and any other correspondence that will help maintain the member's TPL file. The TPL Unit verifies all TPL information submitted with the respective insurance carrier. Mail information about other insurance coverage to:

OHCA TPL Unit
Third Party Liability Update
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

Summary

The following is a summary of the steps used to revise member TPL:

- When a policy is terminated, a patient was never covered, or the insurance carrier has a different billing address than on the TPL resource file, the provider sends the updated TPL information to the TPL Unit.
- If the provider sends documentation from the insurance carrier, the member's TPL file is updated with the corrected information within 10 business days from the date of receipt by the OHCA.
- If the provider sends in documentation that is not from the insurance carrier (discrepancy letter, copy of insurance card, handwritten note, etc.), the TPL unit will contact the insurance carrier to verify the other insurance information and if

appropriate, update the system within 10 business days of receipt.

- The provider does not need to delay filing a claim; however, notifying the TPL Unit of updated TPL data will make subsequent billing easier.
- The provider can download the TPL questionnaire and discrepancy letter form from the OHCA Web site.

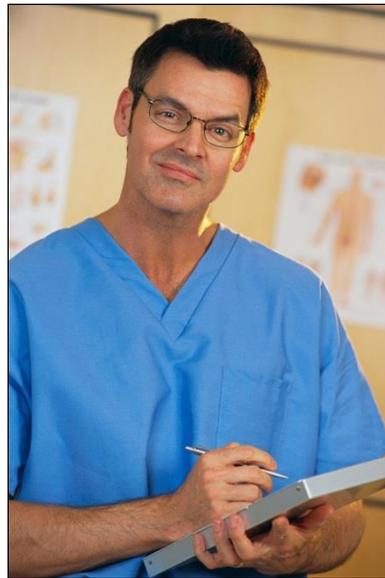
Do not send TPL-related claims to the TPL unit for processing.

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Chapter 15

Prior Authorization



INTRODUCTION

Under the Oklahoma SoonerCare program, there are services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). To obtain additional information on PAs and a list of services that require PA, go to the OHCA Web site at www.okhca.org.

All services requiring PA will be authorized on the basis of the service procedure code or grouping of procedure codes. The OHCA authorization file will reflect the service codes authorized. A PA number will be assigned and a notice generated to the medical provider. The notice of authorization will contain the PA number, the service/procedure code authorized and the number of units or dollar amount allotted. Notices will be provided online for providers using Web services or by mail for all other providers.

SECTION A: PRIOR AUTHORIZATION REQUESTS

Medical and DME Requests

Requests for PA can be submitted by paper, fax or online. All prior authorization of medical or DME services must be submitted on form HCA-12A, the Oklahoma Prior Authorization Request form, and must include an HCA-13A cover sheet for each request.

Requests can be mailed or faxed to:

HP Prior Authorizations

2401 NW 23rd Street, Suite 11

Oklahoma City, OK, 73107

Local: 405-702-9080 or statewide toll-free: 866-574-4991

Online requests for PA are done by visiting the OHCA's SoonerCare Provider Portal found at www.okhca.org.

If a request for prior authorization of medical services is submitted electronically, any documentation including forms HCA-12A and HCA-13A are still required for medical review and must be submitted to the above address or fax number. The SoonerCare Provider Portal will designate a PA number for the online HCA13A form.

HI-TECH Imaging Requests

HI-TECH Imaging Requests (CT, MRA, MRI, PET) for Prior Authorizations can be submitted to the following location:

MedSolutions

Internet: www.medsolutionsonline.com

Phone: 888-693-3281
7:00 am to 8:00 pm (CST)
Monday through Friday

Fax: 888-693-3210
Fax forms available at www.medsolutionsonline.com
or by calling MedSolutions.
NOTE: Only MedSolutions fax forms will be accepted.

Mail: MedSolutions Prior Authorization Department
730 Cool Springs Blvd.
Suite 800
Franklin, TN 37067

Dental Requests

Submit paper requests for PA of dental services on the current American Dental Association (ADA) claim form. Requests for routine procedures require mounted right and left bitewings (or a panoramic x-ray) and periapical x-ray. All orthodontic requests (comprehensive and minor) require submission of study models and a panoramic x-ray. Comprehensive orthodontic requests require a completed Index of Malocclusion form in addition to the ADA claim form. Diagnostic photographs may be submitted in place of study models. This is encouraged if at all possible. Submit paperwork, model and X-ray together. **DO NOT MAIL SEPARATELY**. These requests should be sent to:

OHCA Dental Authorization
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

Pharmacy Requests

Requests for PA for prescription medication should be submitted on the appropriate pharmacy PA forms. These forms are available on the OHCA Web site at www.okhca.org (Screen Sample 15.1). The University of Oklahoma's College of Pharmacy, Medication

Coverage Authorization Unit (MCAU), approves or disapproves each medication authorization request on behalf of the OHCA.

Fax Pharmacy Prior Authorization Request Forms to:

Toll Free: 800-224-4014

Metro Area: 405-271-4014

OHCA Pharmacy Help Desk:

Toll Free: 800-522-0114, *Option 4*

Metro Area: 405-522-6205, *Option 4*

Pharmacy PA Forms:

www.okhca.org/rx-forms

Pharmacy PA Criteria:

www.okhca.org/providers/rx/PA

Pharmacy Web Page

oklahoma health care authority

about us | individuals | providers | research | contact us | search

Home > Providers > Types

Pharmacy

- Calendar
- Drug Utilization Review (DUR) Board
- Enrollment
- ePocrates- Preferred Drug List
- Forms
- Maintenance Drug List
- OTC Analgesic and Decongestant Products
- OTC Pediculicides
- Pharmacy Lock-In Program
- Pharmacy Providers Directory
- Point of Sale NCPDP Codes
- Preferred Prenatal Vitamins
- Prescriber Identification
- Pricing
- Prior Authorizations
- Quantity Limitations
- Supplemental Drug Rebate
- Tamper Resistance Prescription Pads
- Third Party Liability
- Training
- Updates
- Zero Copay Drug List

OHCA Rules

- Pharmacy Rules

Contact Us

- Pharmacy Help Desk: (800) 522-0114, option 4 (405) 522-6205, option 4
- Drug Rebate
 - email: Drug Rebate Unit
- OHCA Pharmacy Administration
 - (405) 522-7492
 - email: Pharmacy
- more contacts »

Resources

- DME provider list
- Electronic Data Interchange
- Family Planning
- Statin Prescription Change Template

Updates

- Medicare prescription drug coverage: Medicare part D.
- updates

Screen Sample 15.1

Outpatient Rehabilitative Behavioral Health, Licensed Behavioral Health Professionals and Psychologist Services

Public and private outpatient behavioral health agencies, and private independent licensed practitioners must complete the Customer Data Core (CDC) Form and submit to the OHCA designated behavioral health utilization management and quality improvement organization. Currently this information must be submitted via the PI Client Information System found at <https://ww4.odmhsas.org/cdc/>. The information provided for pre-admission is brief and is primarily used to track the utilization of various services.

Preadmission services do not require clinical review and will be approved unless the member has exhausted the benefit or another provider has requested prior authorization for additional services.

Inpatient Behavioral Health, Detoxification, Group Home and Therapeutic Foster Care Services

Inpatient psychiatric services for SoonerCare members under the age of 21 must be prior authorized before the service is provided. Telephonic initial and concurrent reviews to determine Medical Necessity Criteria are required for the following services:

- Acute Inpatient Care
- Psychiatric Residential Treatment Facility (PRTF) Services
- Residential Behavior Management Services in Therapeutic Foster Care (TFC) Settings
- Residential Crisis Stabilization

Please contact the OHCA Inpatient Review Request Line for telephonic review contact (800) 522-0114. Please have your Provider ID number ready. Select:

- Option 1 for Provider,
- Option 6 for Prior Authorizations, and
- Option 2 for Behavioral Health

Requests for Services to Illegal/Ineligible Aliens/Soon To Be Sooners

Illegal aliens are only eligible for emergency medical services. Requests for alien services should be submitted to the local county OKDHS office with a notification of needed medical services

form, along with the history/physical and discharge summary. The county OKDHS office staff will complete the appropriate paperwork and forward all information to the OHCA's Provider Services Unit. Requests for emergency medical services to illegal aliens cannot be submitted online. The OHCA Medical Directors Unit approves or disapproves each medical service. If a disability or incapacity determination is required, the OHCA Provider Services Unit will coordinate that decision with the OHCA Level of Care Evaluation Unit (LOCEU). The OHCA Provider Services staff will notify the county OKDHS office of the decision(s) (the approval or denial) of the requested services. The OKDHS county office staff members are responsible for notifying the applicant and the provider of the decision.

SECTION B: PRIOR AUTHORIZATION PROCESS

The OHCA staff will issue a determination for each requested medical/dental service requiring a PA. A computer-generated PA request decision form showing OHCA determination of the service is mailed to the member. The request decision form is not a confirmation of the individual's eligibility for SoonerCare, and the approved clinical period for services may extend beyond the actual period of the member's eligibility. The request decision form serves as notification of the status of a request for PA or a notice of change for the listed services.

Prior authorization represents a clinical decision regarding medical necessity, but is not a guarantee of member eligibility or SoonerCare payment. It is the responsibility of the provider to verify not only SoonerCare eligibility, but also to verify program eligibility and benefit plan (for example: SoonerCare Choice, SoonerCare Traditional) at the time of service. Factors that affect payment are correct claim completion, appropriate referral (if required), provider contract, timely filing and member eligibility.

Retroactive Authorization

Medical Authorization should be requested prior to providing a service. If this is not possible due to urgent or emergency situations, the provider must request authorization within 30 days of the initial date of service. Requests received after 30 days of initial date of service will not be processed. The following conditions must be met for a retroactive medical authorization request to be approved:

1. The services rendered must be covered under the SoonerCare program.
2. The services must be verifiable and medical necessity must be documented.

See the Forms chapter of this manual for an example of the Medical and Dental Prior Authorization request forms.

SECTION C: RECONSIDERATION AND APPEAL PROCEDURES

Level 1 – Reconsideration

All denial reconsiderations for medical/DME and Behavioral Health must be submitted as a new authorization request. The same 30-day retroactive authorization limit applies to all reconsideration requests (i.e. the resubmitted request must be received within 30 days of the initial date of service).

Mail or fax the new authorization request to the appropriate address below:

Medical:

HP Medical Authorizations

2401 NW 23rd Street, Suite 11

Oklahoma City, OK, 73107

Fax: Local 405-702-9080 or statewide toll free 866-574-4991

Pharmacy:

University of Oklahoma College of Pharmacy

Pharmacy Management Consultants

Medication Coverage Authorization Unit

PO Box 26901

ORI W-4403

Oklahoma City, OK 73190

Or fax to: 800-224-4014 or 405-271-4014

Level 2 – Appeal

Dissatisfaction with the results of a review may be disputed by the member only through a formal appeal by returning a completed OHCA LD-2 Form to the OHCA Legal Division within 20 days of Notice of Prior Authorization receipt. Individuals may represent themselves, have another party represent them or have an attorney represent them. An LD-2 form may be obtained from the OHCA

Web site at www.okhca.org, by contacting the Legal Division of the OHCA at 405-522-7217 or by sending a request to:

OHCA Legal Division Docket Clerk
PO Box 18497
Oklahoma City, OK, 73154-0497

In the appeal explain what's being appealed and the reason(s) for the appeal.

SECTION D: HOME & COMMUNITY-BASED SERVICES (HCBS) §1915(C) WAIVER PRIOR AUTHORIZATIONS

Medicaid State Plan services are provided to waiver members. Services that are covered as an integral part of the specific waivers must be prior authorized by the entity or agency that administers the particular waiver under which the member receives services.

ADvantage Waiver
823 S Detroit Ave, 4th Floor
Tulsa, OK 74120

or

ADvantage Waiver
PO Box 50550
Tulsa, OK 74150
918-933-4900
www.okdhs.org/divisionsoffices/visd/asd/advadm

Community Waiver, In-Home Supports Waiver for Adults, In-Home Supports Waiver for Children and the Homeward Bound Waiver:

OKDHS/Developmental Disabilities Services Division (DDSD)
405-521-6267
www.okdhs.org/programsandservices/dd

Personal Care Services:
OKDHS – Personal care services are prior authorized by the OKDHS. Inquiries should be directed to:

OKDHS
Claims Unit
P. O. Box 50550
Tulsa, OK 74150

918-933-4900

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Chapter 16

Financial Services



INTRODUCTION

Financial Services ensure that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied correctly. The financial processing function includes generation of payments to providers and production of a remittance advice (RA) for providers that claims were adjudicated and/or financial transactions were processed. Payments are issued via electronic funds transfer (EFT). The only exceptions are: personal care, individual rehab, aides, respite care and foster care.

The Financial Processing function maintains the following information:

- Payment information (checks and EFTs).
- RA reporting.
- 1099 and W-2 IRS reporting.
- Void, stop payments, re-issuance of payments.

SECTION A: PAYMENT INFORMATION

Payments

The provider has two primary methods of receiving payment from SoonerCare: system-generated check and EFT. These payments, along with the RA, are produced during the financial cycle. The RA, which details each provider's claims and financial transaction activity during the period, is made available to the billing provider through an electronic format to allow verification of billing and payments.

Checks or EFT notices are printed sent/mailed separately from the electronic RA.

Electronic Funds Transfers

Providers use the EFT payment option to expedite funds directly to their designated bank account. EFTs will be the default payment disbursement option for all providers unless it is proven that a provider cannot receive an EFT transaction.

Those who cannot receive an EFT will receive their payment by paper check.

Manual Payments

A less common method for provider payment receipt is the paper warrant issuance (check).

State Agency Funds Transfers

For all state agencies participating in the Oklahoma Medicaid program, payments will be disbursed via state agency funds transfers. Since the Oklahoma Medicaid program is operated by a state agency, the funds are transferred to the corresponding state agency participating in the Oklahoma Medicaid program.

SECTION B: RA

OHCA providers receive a weekly RA for any claims submitted the previous week. The RA identifies claims that have been paid, denied, in process or adjusted. The RA includes the client ID number, the provider number, the Internal Control Number (ICN) of the claim processed, the date(s) of service and paid amount. The RA also details any reductions to the paid amount, for reasons such as TPL and/or client co-payment. Each claim detail might have an explanation of benefit (EOB) code explaining the reason for payment, denial, adjustment or in-process statuses. RAs are tailored to individual claim form types (for example: 1500, UB-04, Dental, and Pharmacy) and where appropriate, include additional information like procedure code, revenue code or admission and discharge date for providers that bill on the UB-04 claim form.

The RA has several document types in this order:

- 1 Check or EFT advice (if applicable)
- 2 Address page
- 3 Banner messages (if applicable)
- 4 Claims activity/status reports (if applicable)
 - a Ordered by claim type (Physician, Institutional, Dental, Pharmacy)

- b Ordered by claim status (paid, denied, in process, adjusted)
- 5 Financial transactions
 - a Expenditures (system generated only)
 - b Cash receipts
 - c Accounts receivable
- 6 TPL information (if applicable)
- 7 EOB descriptions (if applicable)
- 8 Summary report

The RA is generated in each claims payment cycle. A provider will receive an RA if the provider has activity during the claim cycle or outstanding accounts receivable.

Remittance Advice Section Descriptions

The RA contains the following information:

Medicare Crossover Paid

Claims with a paid status are shown in this RA series, including claims paid at zero.

Medicare Crossover Denied

These claims have been denied payment.

Medicare Crossover In Process

Claims in the processing cycle not finalized are listed in this RA series. Claims found here include

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
- with adjustments that have not been finalized.

These claims have not been denied. Claims reflected as In Process are ultimately shown as paid, denied or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

Claims Paid

Claims with a paid status are shown in this RA series, including claims paid at zero.

Claims Denied

These claims have been denied payment.

Claims in Process

Claims in the processing cycle that have not been finalized are listed in this RA series. Claims found here include

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
- with adjustments that have not been finalized.

These claims have not been denied. Claims reflected as In Process are ultimately shown as paid, denied, or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

NOTE: *Each claim in process lists the EOB message that corresponds to the reason it has been suspended.*

Claim Adjustments

Adjusted claims are listed in this RA series. Two header lines are shown for each adjusted claim. The first header line is for the original or *mother* claim, while the second header line is for the adjusted or *daughter* claim.

Financial Transactions

Non-claim-specific payouts, refunds, and accounts receivable (A/R) transactions are listed in this series of the RA. A transaction number is used to uniquely identify each financial transaction. If a financial transaction is associated to a cash receipt, the cash control number (CCN) is also displayed for informational purposes. Examples of miscellaneous financial transactions tabulated in this RA section include

1. non claims specific payouts to a provider;
2. refunds made to the OHCA by a provider not associated with a single claim; and

3. amounts scheduled for recoupment, which the A/R section tracks repayment of to determine amount to be recouped.

EOB Code Descriptions

Explanation of Benefits (EOB) codes applied to submitted claims are listed along with the respective code narrative. These codes and corresponding narratives describe the reasons submitted claims were suspended, denied or not paid in full.

Summary

Data from the entire RA series are reflected on this page. This section summarizes all claim and financial activity for each weekly cycle and reports year-to-date totals.

Remittance Advice Sorting Sequence

Claims are shown on the RA by type and according to the following priority sequence:

1500

1. Alphabetically by member name.
2. Alphanumerically by patient number assigned by the provider.
3. Numerically by ICN.

UB-04

1. Alphabetically by member name.
2. Alphanumerically by patient number assigned by the provider.
3. Numerically by ICN.

Drug

1. Alphanumerically by prescription number.
2. Alphabetically by member name.
3. Numerically by ICN.

Dental

1. Alphabetically by member name.

2. Numerically by ICN.

EOB Codes

EOB codes are provided with each RA. These codes and the corresponding details describe the reason submitted claims were suspended, denied, or not paid in full. Because the claim can have edits and audits at both the header and detail levels, EOB codes are listed for both header and detail information. A maximum of 20 EOBs are listed for the header, and a maximum of 20 EOBs are listed for each detail line.

Exceptions are suspended claims, which have a maximum of two EOBs per header and detail. **These are not denial codes, but rather the reason the claim is being reviewed.** EOB data are listed immediately following the claim header and detail information beside the caption of the EOB. EOB 00 lists header codes, EOB 01 lists line one of the claim's codes, and EOB 02 lists line two of the claim's codes. If there are no EOBs posted for a particular EOB XX line, the line is not printed. Explanation of benefits and denial information are provided in HIPAA compliant formats.

For more detailed EOB and denial information, providers are encouraged to use the OHCA SoonerCare Provider Portal available at www.okhca.org. Once there, use the claim inquiry option. An additional resource for this information can be found by calling 800-522-0114 and selecting option 1, for claim status.

For more information about HIPAA, please visit:
www.cms.hhs.gov

For a detailed listing of these new HIPAA codes, visit:
www.wpc-edi.com/ClaimAdjustment_40.asp.

Remittance Advice Examples

The following pages display examples of the OHCA RA and detailed information regarding the statements. The illustrative samples give examples of where the data are found on the RA document. Examples that follow the illustrative samples include claims adjudication pages for each claim type. The examples are a representative sample of what a provider might see on an RA. This is not a comprehensive listing for each claim type.

REPORT: CRA-0006-W
 PROCESS: FNI03011
 LOCATION: FINJW201

STATE OF OKLAHOMA
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 CMS 1500(a) CLAIMS PAID(b)

DATE: 02/25/2004
 PAGE: 1

HOLIDAY, KASON
 1515 NORTH STREET(f)
 OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted & Recouped

PAYEE NUMBER 123456789 A(c)
 PAYMENT NUMBER 333222000(d)
 ISSUE DATE 02/25/2004(e)

--ICN--	SERVICE DATES FROM THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	REIMB. AMOUNT	PAID AMOUNT
CLIENT NAME: MARY ZEPHEREZ 2204365123456	020404 020404	150.00	150.00	0.00	0.00	0.00	150.00	150.00
				CLIENT NO.: 222555888				
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL E OBS
11	90801		1.00	020404 020404	212345678	150.00	150.00	A2

- (a) Claim types are separated by pages and are indicated in the title: CMS-1500, inpatient, outpatient, Part B Medicare Crossovers, Part A Medicare Crossovers, Dental, and Drug
- (b) Each page has a title: Paid, Denied, In-Process, and Adjustments
- (c) Payee Number is the billing provider's Medicaid number and service location code
- (d) Payment Number is the warrant (check) number
- (e) Issue Date is the effective date of the Electronic Funds Transfer or the date printed on a paper check
- (f) Address is the "Pay To" provider address

REPORT: CRA-0116-
 PROCESS: FNIO3011
 LOCATION:FINJW201

STATE OF OKLAHOMA
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 CMS 1500 CLAIM ADJUSTMENTS

DATE: 02/25/2004
 PAGE: 2

HOLIDAY, KASON
 1515 NORTH STREET
 OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted & Recouped

PAYEE NUMBER 123456789 A
 PAYMENT NUMBER 333222000
 ISSUE DATE 02/25/2004

--ICN--	SERVICE DATES	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	REIMB.	PAID
--PATIENT NUMBER	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
CLIENT NAME: MARY ZEPHEREZ		CLIENT NO.: 222555888						
2204365123456(a) 1330699	020204	020204	(150.00)		0.00	0.00		(150.00) (b)
				(150.00)	0.00		(150.00)	
5204365002099(c) 1330699	020204	020204	125.00		0.00	0.00		125.00(d)
				125.00	0.00		125.00	

HEADER EOBS: 129

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL EOBS
				FROM	THRU	AMOUNT	AMOUNT	
11	90806		1.00	020204	020204	123456788	125.00	100 A2

NET OVERPAYMENT (AR) 25.00(e)

- (a) Original or active claim appears first and is reversed with negative dollar amounts (1.1.)
- (b) Claim is reprocessed and given a 50 series ICN beneath the original or active claim
- (c) 50 series ICN is now the current active claim
- (d) New ICN processes for payment or denial
 - If the new claim process for additional payment, the difference between the original payment and the new payment will result in an additional payment
- (e) If the new claim process for less than the original claim, the difference becomes an Accounts Receivable

REPORT: CRA-0000-W STATE OF OKLAHOMA DATE: 02/25/2004

PROCESS: FNIO3011
 LOCATION: FINJW201

MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 FINANCIAL TRANSACTIONS

PAGE: 3

HOLIDAY, KASON
 1515 NORTH STREET
 OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted & Recouped

PAYEE NUMBER 123456789
 PAYMENT NUMBER 333222000
 ISSUE DATE 02/25/2004

-----NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS(a)-----

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	RENDERING PROVIDER	SVC DATE FROM THRU	CLIENT NO.	CLIENT NAME
-----------------------	---------	----------------------	----------------	-----------------------	-----------------------	------------	-------------

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

-----NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS(b)-----

--CCN--	REFUND --AMOUNT--	REASON CODE	CLIENT NO.	CLIENT NAME
---------	----------------------	----------------	------------	-------------

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

-----ACCOUNTS RECEIVABLE(c)-----

A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL --AMOUNT--	TOTAL -RECOUPED-	--BALANCE--	REASON CODE
5204365002099	021804	25.00	25.00	25.00	0.00	8400

(a) Non-Claim Specific Payout to Providers: Disproportionate Share Payments (Hospitals)

(b) Non-Claim Specific Refunds From the Providers: Provider submits a check that goes against an Accounts Receivable not associated with a claim

(c) Accounts Receivable

- A/R number is the Adjustment ICN if the Accounts Receivable is claim related
- Recouped this Cycle: Amount subtracted from current warrant amount and decreased the amount of AR.
- Original Amount: The dollar amount at the time the Accounts Receivable was set up
- Total Recouped: How much has been satisfied to date
- If a balance remains, the Accounts Receivable will carry over to the next weeks RA

REPORT: CRA-0148-W
 PROCESS: FNI03011
 LOCATION: FINJW201

STATE OF OKLAHOMA
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 SUMMARY

DATE: 02/25/2004
 PAGE: 4

HOLIDAY, KASON
 1515 NORTH STREET
 OKLAHOMA CITY, OK 74601-0000

For Illustrative Purpose Only
Professional Claim Example-Paid, Adjusted & Recouped

PAYEE NUMBER 123456789 A
 PAYMENT NUMBER 333222000
 ISSUE DATE 02/25/2004

-----CLAIMS DATA-----			
	CURRENT NUMBER	CURRENT AMOUNT	YTD(a) NUMBER
CLAIMS PAID	1	150.00	1
CLAIM ADJUSTMENTS	1	(25.00)	1
TOTAL CLAIMS PAYMENTS	1	125.00	1
CLAIMS DENIED	0		0
CLAIMS IN PROCESS	0		
-----EARNINGS DATA-----			
PAYMENTS:			
CLAIM PAYMENTS		150.00	150.00
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)		0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):			
CLAIM SPECIFIC:			
CURRENT CYCLE		(25.00)	(25.00)
OUTSTANDING FROM PREVIOUS CYCLES		0.00	0.00
NON-CLAIM SPECIFIC OFFSETS			
FICA WITHHELD		0.00	0.00
NET PAYMENT		125.00	125.00
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS		0.00	0.00
NON-CLAIM SPECIFIC REFUNDS		0.00	0.00
OTHER FINANCIAL:			
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)		0.00	0.00
VOIDS		0.00	0.00
NET EARNINGS		125.00	125.00

(a) and (b) Year to Date is running total of what the provider's 1099 will be at the end of the calendar year

COMPOUND DRUG CLAIMS PAID

Remittance Advice - Compound Drug Claims Paid Report Layout

REPORT: CRA-0001-W	STATE OF OKLAHOMA				DATE: MMDDYY				
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM				PAGE: 9,999				
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE								
	COMPOUND DRUG CLAIMS PAID								
XX					PAYEE NUMBER 999999999 X				
XX					PAYMENT NUMBER 999999999				
XX					ISSUE DATE MMDDYY				
XXXXXXXXXXXXXXXXXX, XX 99999-9999									
	DISPENSE RENDERING	BILLED	ALLOWED	TPL	CO-PAY	SPENDDOWN	REIMB. PAID		
--ICN--	RX NO. DATE PROVIDER	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	
CLIENT NAME:	XX	CLIENT NO.:	XXXXXXXXXXXXXXXXXX						
	RRYYJJBBSSS XXXXXXXX MMDDYY XXXXXXXX	9,999,999.99	9,999,999.99	9,999,999.99	999,999.99	999,999.99	9,999,999.99	9,999,999.99	
HEADER EOB:	9999 9999								
NDC	UNITS	ALLOWED	EOB CODES						
XXXXXXXXXXXXX	999999	9,999,999.99	9999 9999						
XXXXXXXXXXXXX	999999	9,999,999.99	9999 9999						
XXXXXXXXXXXXX	999999	9,999,999.99	9999 9999						
XXXXXXXXXXXXX	999999	9,999,999.99	9999 9999						
	TOTAL COMPOUND DRUG CLAIMS PAID:		99,999,999.99		9,999,999.99		99,999,999.99		

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed	The computed detail level allowed amount for dispensed drug under the Medical assistance program being billed.	Number	9
Allowed Amount	The computed dollar amount for the dispensed drug under the Medical Assistance Program being billed. This amount is determined by totaling prices of all ingredient used to formulate the compound.	Number	9
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	City where payee resides.	Character	15
Client Number	Client's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	The dollar amount member should pay and is deducted from the allowed amount. The co-pay amount that is deducted depends on the type of drug dispensed.	Number	8
Dispense Date	The date drug was dispensed to member. This serves as the service date for drug claims.	Character	6
EOB Codes	The detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
Header EOBS	The EOB codes that apply to the header on the compound drug claim form. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date payment was issued.	Character	10
NDC	National Drug Codes correspond to the ingredients used. A maximum of 15 ingredients can be entered on one claim.	Character	11
Paid Amount	Dollar amount paid for drug. This is determined by computing allowable amount for drug and deducting TPL, and/or co-pay amounts.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated, this is the payment number corresponding to the check or EFT generated.	Number	9

Field	Description	Data Type	Length
Provider Name	Payee's name.	Character	50
RX NO.	Prescription number on the prescription used to dispense the drug.	Character	7
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
Total Compound Drug Claims Paid - Allowed	Total amount allowed for payee claims.	Number	10
Total Compound Drug Claims Paid - Billed	Total amount billed for payee.	Number	10
Total Compound Drug Claims Paid - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Compound Drug Claims Paid - Paid	Total amount paid for payee's claims.	Number	10
Total Compound Drug Claims Paid - Reimbursement	Total amount reimbursed for payee's claims.	Number	10
Total Compound Drug Claims Paid - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Claims Paid - TPL	Total amount of TPL for payee's claims.	Number	10
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Member's name.	Character	29
Dispense Date	Date drug was actually dispensed to member. This serves as service date for drug claims.	Character	8
EOB Codes	These are the Detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
Header EOBS	These are the EOB codes that apply to the header on the compound drug claim form. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date payment was issued.	Character	10
NDC	These are the National Drug Codes that pertain to the ingredients used in the compound. There is a maximum number of 15 ingredients that can be entered on one claim.	Character	11
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated, this is the payment number corresponding to the check or EFT generated.	Number	9
Provider Name	Payee's name.	Character	50
RX NO.	Indicates the prescription number on the prescription that was used to dispense the drug.	Character	7
Rendering Provider Number	The number used to identify the provider that performed the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9

Field	Description	Data Type	Length
Total Compound Drug Claims Denied - Billed	Total amount billed by the payee.	Number	10
Total Compound Drug Claims Denied - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Claims Denied - TPL	Total amount of TPL for payee's claims.	Number	10
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

COMPOUND DRUG CLAIM IN PROCESS

Remittance Advice - Compound Drug Claims In Process Report Layout

REPORT: CRA-0003-W
 PROCESS: FNIO3011
 LOCATION: FINJW201

STATE OF OKLAHOMA
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 COMPOUND DRUG CLAIMS IN PROCESS

DATE: MMDDYY
 PAGE: 9,999

XX
 XXX
 XXX
 XXXXXXXXXXXXXXX, XX 99999-9999

PAYEE NUMBER 999999999 X
 PAYMENT NUMBER 999999999
 ISSUE DATE MMDDYY

--ICN--	RX NO.	DISPENSE DATE	RENDERING PROVIDER	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
CLIENT NAME: XXX CLIENT NO.: XXXXXXXXXXXXXXX						
	RYYJJBBSSS	XXXXXXX	MMDDYY XXXXXXXX	9,999,999.99	9,999,999.99	999,999.99
HEADER EOB: 9999						
NDC	UNITS	EOB CODES				
XXXXXXXXXXXX	999999	9999	9999	9999	9999	9999
XXXXXXXXXXXX	999999	9999	9999	9999	9999	9999
XXXXXXXXXXXX	999999	9999	9999	9999	9999	9999
XXXXXXXXXXXX	999999	9999	9999	9999	9999	9999
XXXXXXXXXXXX	999999	9999	9999	9999	9999	9999
XXXXXXXXXXXX	999999	9999	9999	9999	9999	9999
TOTAL COMPOUND DRUG CLAIMS IN PROCESS:				99,999,999.99	99,999,999.99	9,999,999.99

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	The city in which the payee lives.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Dispense Date	Date drug was actually dispensed to member. This serves as service date for drug claims.	Character	8
EOB Codes	These are the detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
Header EOBS	These are the EOB codes that apply to the header on the compound drug claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA reason code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
NDC	These are the national drug codes that pertain to the ingredients used in the compound. There is a maximum of 15 ingredients that can be entered on one claim.	Character	11
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated, this is the check number corresponding to the check generated. If the provider is an EFT participant, this is the control number of the EFT transaction.	Number	9
Provider Name	Payee's name.	Character	50
RX NO.	Indicates the prescription number on the prescription used to dispense the drug.	Character	7
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State in which the payee resides.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
Total Compound Drug	Total amount billed for payee.	Number	10

Field	Description	Data Type	Length
Claims In Process - Billed			
Total Compound Drug Claims In Process - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Claims In Process - TPL	Total amount of TPL for payee's claims.	Number	10
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed	Computed detail-level dollar amount allowable for dispensed drug under the medical assistance program being billed.	Number	9
Allowed Amount	Computed dollar amount allowable for dispensed drug under the medical assistance program being billed. Pricing each ingredient used to formulate the compound and adding up the individual prices will produce this amount.	Number	9
Billed Amount	Dollar amount requested by the provider for dispensed drug.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that the member should pay and is deducted from the allowed amount to arrive at the paid amount. The co-pay amount that is deducted depends on the type of drug dispensed.	Number	8
Dispense Date	Date drug was actually dispensed to member. This serves as service date for drug claims.	Character	8
EOB Codes	These are the EOB codes that apply to the header on the compound drug claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBS	These are the EOB codes that apply to the header on the compound drug claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	Unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13

Field	Description	Data Type	Length
Issue Date	Date check was issued.	Character	10
NDC	These are the national drug codes that pertain to the compound ingredients. There is a maximum of 15 ingredients that can be entered on one claim.	Character	11
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Net Overpayment (AR)	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	Dollar amount paid for drug. Computing the allowable amount for the drug and deducting the TPL, and/or co-pay amounts determine this.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name.	Character	50
RX NO.	Indicates the prescription number on the prescription that was used to dispense the drug.	Character	7
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
TPL Amount	Dollar amount paid for drug by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9

Field	Description	Data Type	Length
Total Compound Drug Adjustments Claims Paid - Allowed	Total amount allowed for payee claims.	Number	10
Total Compound Drug Adjustments Claims Paid - Billed	Total amount billed for payee.	Number	10
Total Compound Drug Adjustments Claims Paid - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Compound Drug Adjustments Claims Paid - Paid	Total amount paid for payee's claims.	Number	10
Total Compound Drug Adjustments Claims Paid - Reimbursement	Total amount reimbursed for payee's claims.	Number	10
Total Compound Drug Adjustments Claims Paid - Spend down	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Compound Drug Adjustments Claims Paid - TPL	Total amount of TPL for payee's claims.	Number	10
Total No. Adj	Total count of number of adjustments on RA for the provider.	Number	6
Units	Quantity of ingredient(s) used.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

DENTAL CLAIMS PAID

Remittance Advice - Dental Claims Paid Report Layout

REPORT: CRA-0005-W	STATE OF OKLAHOMA										DATE: MMDDYY									
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM										PAGE: 9,999									
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE																			
	DENTAL CLAIMS PAID																			
XXXXXXXXXXXXXXXXXXXXXXXXXXXX										PAYEE NUMBER	999999999 X									
XXXXXXXXXXXXXXXXXXXXXXXXXXXX										PAYMENT NUMBER	999999999									
XXXXXXXXXXXXXXXXXXXXXXXXXXXX										ISSUE DATE	MMDDYY									
XXXXXXXXXXXXXXXXXXXX, XX 99999-9999																				
--ICN--	RENDERING PROVIDER	SERVICE DATES FROM THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	REIMB. AMOUNT	PAID AMOUNT											
CLIENT NAME:	XXXXXXXXXXXXXXXXXXXXXXXXXXXX										CLIENT NO.:	999999999999								
RYYJJBBSS	XXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999,999.99	999,999.99	9,999,999.99	9,999,999.99											
HEADER EOBS:	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999										
PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS													
XX	XXXXXX	99	XXXXX	MMDDYY	9,999,999.99	9,999,999.99	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
XX	XXXXXX	99	XXXXX	MMDDYY	9,999,999.99	9,999,999.99	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
XX	XXXXXX	99	XXXXX	MMDDYY	9,999,999.99	9,999,999.99	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
XX	XXXXXX	99	XXXXX	MMDDYY	9,999,999.99	9,999,999.99	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
TOTAL DENTAL CLAIMS PAID:					99,999,999.99	99,999,999.99	99,999,999.99		9,999,999.99		99,999,999.99									
						99,999,999.99		9,999,999.99												

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed Amount	Computed dollar amount allowable for services rendered on each detail line under the medical assistance program being billed. May occur 12 times depending on the number of detail lines billed.	Number	9
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
Paid Amount	Dollar amount paid for the services rendered. Computing allowable amount for the services and deducting the TPL amount determine this.	Number	9

Field	Description	Data Type	Length
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Claims Paid - Allowed	Total allowed amount for payee's claims.	Number	10
Total Dental Claims Paid - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Claims Paid - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Dental Claims Paid - Paid	Total amount paid for payee's claims.	Number	10
Total Dental Claims Paid - Reimbursement	Total amount reimbursed for payee's claims.	Number	10
Total Dental Claims Paid - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Claims Paid - TPL	Total amount of TPL for payee's claims.	Number	10

Field	Description	Data Type	Length
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

DENTAL CLAIMS DENIED

Remittance Advice - Dental Claims Denied Report Layout

REPORT: CRA-0006-W PROCESS: FNIO3011 LOCATION: FINJW201	STATE OF OKLAHOMA MEDICAID MANAGEMENT INFORMATION SYSTEM PROVIDER REMITTANCE ADVICE DENTAL CLAIMS DENIED	DATE: MMDDYY PAGE: 9,999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, XX 99999-9999		PAYEE NUMBER 999999999 X PAYMENT NUMBER 999999999 ISSUE DATE MMDDYY
--ICN--	RENDERING PROVIDER SERVICE DATES FROM THRU	BILLED AMOUNT TPL AMOUNT SPENDDOWN AMOUNT
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXXXXXX RRYJJBBSSS XXXXXXXX MMDDYY MMDDYY 9,999,999.99 9,999,999.99 999,999.99		
HEADER EOB: 9999		
PL SERV PROC CD TOOTH SURFACE DATE SVC PERF BILLED AMOUNT XX XXXXXX 99 99999 MMDDYY 9,999,999.99	DETAIL EOB: 9999	
XX XXXXXX 99 99999 MMDDYY 9,999,999.99	9999 9999	
XX XXXXXX 99 99999 MMDDYY 9,999,999.99	9999 9999	
XX XXXXXX 99 99999 MMDDYY 9,999,999.99	9999 9999	
XX XXXXXX 99 99999 MMDDYY 9,999,999.99	9999 9999	

TOTAL DENTAL CLAIMS DENIED: 99,999,999.99 99,999,999.99 9,999,999.99

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used	Character	5

Field	Description	Data Type	Length
	to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.		
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Claims Denied - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Claims Denied - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Claims Denied - TPL	Total amount of TPL for payee's claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

DENTAL CLAIMS IN PROCESS

Remittance Advice - Dental Claims In Process Report Layout

REPORT: CRA-0007-W	STATE OF OKLAHOMA		DATE: MMDDYY
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM		PAGE: 9,999
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE		
	DENTAL CLAIMS IN PROCESS		
XXXXXXXXXXXXXXXXXXXXXXXXXXXX			PAYEE NUMBER 99999999 X
XXXXXXXXXXXXXXXXXXXXXXXXXXXX			PAYMENT NUMBER 99999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX			ISSUE DATE MMDDYY
XXXXXXXXXXXXXXXXXXXX, XX 99999-9999			
--ICN--	RENDERING PROVIDER	SERVICE DATES FROM THRU	BILLED AMOUNT TPL AMOUNT SPENDDOWN AMOUNT
CLIENT NAME: RRYJJJBBSSS	XXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99 9,999,999.99 999,999.99
CLIENT NO.: 999999999999			
HEADER EOB: 9999	9999	9999	9999 9999
PL SERV	PROC CD	TOOTH SURFACE	DATE SVC PERF BILLED AMOUNT
XX	XXXXXX	99 XXXXX	MMDDYY 9,999,999.99
			DETAIL EOB: 9999
XX	XXXXXX	99 XXXXX	MMDDYY 9,999,999.99
			9999 9999
XX	XXXXXX	99 XXXXX	MMDDYY 9,999,999.99
			9999 9999
XX	XXXXXX	99 XXXXX	MMDDYY 9,999,999.99
			9999 9999
XX	XXXXXX	99 XXXXX	MMDDYY 9,999,999.99
			9999 9999
TOTAL DENTAL CLAIMS IN PROCESS:			99,999,999.99 99,999,999.99 9,999,999.99

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates From	Earliest date of service on detail lines.	Character	6

Field	Description	Data Type	Length
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Claims In Process - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Claims In Process - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Claims In Process - TPL	Total amount of TPL for payee's claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

DENTAL CLAIM ADJUSTMENTS

Remittance Advice - Dental Claim Adjustments Report Layout

REPORT: CRA-0008-W	STATE OF OKLAHOMA							DATE: MMDDYY		
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM							PAGE: 9,999		
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE									
	DENTAL CLAIM ADJUSTMENTS									
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX							PAYEE NUMBER	999999999 X		
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX							PAYMENT NUMBER	999999999		
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX							ISSUE DATE	MMDDYY		
XXXXXXXXXXXXXXXXXX, XX 99999-9999										
--ICN--	RENDERING PROVIDER	SERVICE DATES FROM THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT	CO-PAY AMOUNT	REIMB. PAID AMOUNT	AMOUNT	
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXXX										
	RRYYJJBBBMMOM	XXXXXXXXXX MMDDYY MMDDYY	(9,999,999.99)	(9,999,999.99)	(9,999,999.99)	(999,999.99)	(999,999.99)	(9,999,999.99)	(9,999,999.99)	
	RRYYJJBBBSSS	XXXXXXXXXX MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999,999.99	999,999.99	9,999,999.99	9,999,999.99	
HEADER EOBS: 9999										
PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS			
XX	XXXXXX	99	99999	PERF MMDDYY	9,999,999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999			
							ADDITIONAL PAYMENT			9,999,999.99
							NET OVERPAYMENT			9,999,999.99
							REFUND AMOUNT APPLIED			9,999,999.99
TOTAL NO. OF ADJ: 999,999										
TOTAL DENTAL ADJUSTMENT CLAIMS:			99,999,999.99		99,999,999.99		9,999,999.99		9,999,999.99	
				99,999,999.99		9,999,999.99		99,999,999.99		

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	Computed dollar amount allowable for services rendered on each detail line under the medical assistance program being billed. May occur 12 times depending on the number of detail lines billed.	Number	9
Billed Amount	Dollar amount requested by the provider for service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Date SVC PERF	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Detail EOBs	These are the detail EOB codes that apply to the detail on the dental claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBs	These are the header EOB codes that apply to the header on the dental claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	Unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9

Field	Description	Data Type	Length
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
Paid Amount	Dollar amount paid for the services rendered. This is determined by computing allowable amount for the services and deducting the TPL amount.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service on the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Surface	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
TPL Amount	Dollar amount paid for services by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at paid amount.	Number	9
Tooth	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
Total Dental Adjustments Claims - Allowed	Total allowed amount for payee's claims.	Number	10

Field	Description	Data Type	Length
Total Dental Adjustments Claims - Billed	Total billed amount for payee's claims.	Number	10
Total Dental Adjustments Claims - Co-Pay	Total amount of co-pay for payee's claims.	Number	9
Total Dental Adjustments Claims - Paid	Total amount paid for payee's claims.	Number	10
Total Dental Adjustments Claims - Reimbursement	Total amount reimbursed for payee's claims.	Number	10
Total Dental Adjustments Claims - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Dental Adjustments Claims - TPL	Total amount of TPL for payee's claims.	Number	10
Total No. Adj	Total count of number of adjustments on RA for the provider.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Blood Deductible	Amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay AMT	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.	Number	8
EOB Sequence Code	This is the sequential line number of the EOB code line.	Number	2
EOBs	These are the Detail EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30

Field	Description	Data Type	Length
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
Total Medicare Crossover Part B Claims Paid - Billed Amt	This amount reflects the total of all billed amounts for the Medicare Part B Crossover claims.	Number	10
Total Medicare Crossover Part B Claims Paid - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Co - Insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Paid - Paid Amt	This amount reflects the total of all the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Claims Paid - Reimbursement	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part B Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Blood Deductible	This is the amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBs	These are the Detail EOB codes that apply to the header on the claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6

Field	Description	Data Type	Length
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part B Claims Denied - Billed Amt	This amount reflects the total billed amount for the Medicare Part B Crossover claims.	Number	10
Total Medicare Crossover Part B Claims Denied - Blood Deductible Amt	This amount reflects the total amount of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Denied - Co - Insurance Amt	This amount reflects the total amount of all co-insurance amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Denied - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	10
Total Medicare Crossover Part B Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Blood Deductible Amount	Amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
EOB Codes	These are the Detail EOB codes that apply to the header on the claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part B Claims in Process - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Claims in Process - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims in Process - Co - Insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims in Process - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Claims in Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part B Claims in Process - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Blood Deductible Amount	This is the amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.	Number	8
EOB Codes	These are the Detail EOB codes that apply to the header on the dental claim form. There could be a maximum of 20 EOB codes per claim header. See HIPAA Reason Code for detailed information on EOBs.	Number	4
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
ICN	This is the unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8

Field	Description	Data Type	Length
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part B Adj Claims - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part B claims.	Number	10
Total Medicare Crossover Part B Adj Claims - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part B claims.	Number	9
Total Medicare Crossover Part B Adj Claims - Co - Insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part B claims Adjustments.	Number	9
Total Medicare Crossover Part B Adj Claims - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part B claims Adjustments.	Number	9
Total Medicare Crossover Part B Adj Claims - Deductible Amt	This amount reflects the total of all deductible amounts for the Medicare Crossover Part B claims Adjustments.	Number	9

Field	Description	Data Type	Length
Total Medicare Crossover Part B Adj Claims - Paid Amt	This amount reflects the total of all the Medicare Crossover Part B claims Adjustments.	Number	10
Total Medicare Crossover Part B Adj Claims - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part B claims Adjustments.	Number	10
Total Medicare Crossover Part B Adj Claims - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part B Adj Claims - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part B claims Adjustments.	Number	10
Total No. Adj	This is the total number of claims adjusted for the current financial cycle.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Allowed Amount	The computed allowable dollar amount for claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Days	Total days member was in hospital.	Number	3
Detail EOBs	EOB codes.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	These are the Header EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates level of patient care.	Character	3
Paid Amount	The dollar amount payable for claim.	Number	9
Patient Acct Number	This is a unique number assigned by the provider usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9

Field	Description	Data Type	Length
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Inpatient claims Paid - Allowed Amt	This amount reflects the allowed amount total of all the inpatient claims.	Number	10
Total Inpatient claims Paid - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the inpatient claims paid.	Number	9
Total Inpatient claims Paid - Paid Amt	This amount reflects the total of all the inpatient claims paid.	Number	10
Total Inpatient claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the inpatient claims paid.	Number	10
Total Inpatient claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9

Field	Description	Data Type	Length
Total Inpatient claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the inpatient claims paid.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

INPATIENT CLAIMS DENIED

Remittance Advice - Inpatient claims Denied Report Layout

REPORT: CRA-0022-W STATE OF OKLAHOMA DATE: MMDDYY
 PROCESS: FNIO3011 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 9,999
 LOCATION: FINJW201 PROVIDER REMITTANCE ADVICE
 INPATIENT CLAIMS DENIED

XX
 XX
 XX
 XXXXXXXXXXXXXXXXXXX, XX 99999-9999

PAYEE NUMBER 999999999 X
 PAYMENT NUMBER 999999999
 ISSUE DATE MMDDYY

--ICN--	ATTENDING	PROV.	SERVICE	DATES	DAYS	ADMIT	BILLED	TPL	SPENDDOWN
PATIENT ACCT. NUM.	FROM	THRU	DATE	AMOUNT	AMOUNT	AMOUNT			

CLIENT NAME: XX CLIENT NO.: XXXXXXXXXXXXXXXX
 RRYJJJBBBSSS XXXXXXXXXXXX MMDDYY MMDDYY 999 MMDDYY 9,999,999.99 9,999,999.99 999,999.99
 XX

HEADER EOBS: 9999

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL	EOBS
999	XXXXXX	MMDDYY	XXX	999999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999	
999	XXXXXX	MMDDYY	XXX	999999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999	
999	XXXXXX	MMDDYY	XXX	999999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999	
999	XXXXXX	MMDDYY	XXX	999999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999	
999	XXXXXX	MMDDYY	XXX	999999.99	9,999,999.99	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999	

TOTAL INPATIENT CLAIMS DENIED: 99,999,999.99 99,999,999.99 9,999,999.99

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
Detail EOBs	EOB codes.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates what level of care the patient was rendered.	Character	3
Patient Acct Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. These might occur 23 times depending on the number of detail lines billed.	Number	3
SRV Date	These are the dates the services were actually rendered. Each detail line will have	Character	6

Field	Description	Data Type	Length
	a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.		
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Inpatient claims Denied - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the denied inpatient claims.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number. Unique identifier of the client.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates what level of care the patient was rendered.	Character	3
Patient Acct Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3

Field	Description	Data Type	Length
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	This is the state in which the payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Inpatient claims In Process - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims In Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the inpatient claims.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Allowed Amount	The computed allowable dollar amount for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	The dollar amount billed by the provider for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	The dollar amount that the member should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	8
Days	Total days member was in hospital.	Number	3
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8

Field	Description	Data Type	Length
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is the unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This field indicates what level of care the patient was rendered.	Character	3
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	This is the dollar amount that is payable for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Patient Acct Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid for the services by any source outside of the state Medical Assistance Program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total Inpatient claims Adjustments - Allowed Amt	This amount reflects the allowed amount total of all the inpatient claims.	Number	10
Total Inpatient claims Adjustments - Billed Amt	This amount reflects the total billed amount of all the inpatient claims.	Number	10
Total Inpatient claims Adjustments - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the inpatient claims.	Number	9
Total Inpatient claims Adjustments - Paid Amt	This amount reflects the total of all the inpatient claim adjustments.	Number	10
Total Inpatient claims Adjustments - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the inpatient claims Adjustments.	Number	10
Total Inpatient claims Adjustments - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Inpatient claims Adjustments - TPL Amt	This amount reflects the total of all TPL amounts for the inpatient claims adjustments.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6

Field	Description	Data Type	Length
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed Amount	The computed allowable dollar amount for claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBs	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Paid Amount	The dollar amount that is payable for the claim.	Number	9
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9

Field	Description	Data Type	Length
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid by sources other than the medical assistance program being billed for the member's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Outpatient Claims Paid - Allowed Amt	This amount reflects the allowed amount total of all outpatient claims.	Number	10
Total Outpatient Claims Paid - Billed Amt	This amount reflects the total billed amount of all the outpatient claims.	Number	10
Total Outpatient Claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the outpatient claims.	Number	9
Total Outpatient Claims Paid - Paid Amt	This amount reflects the total of all the Outpatient Claims paid.	Number	10
Total Outpatient Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the outpatient claims.	Number	10
Total Outpatient Claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9

Field	Description	Data Type	Length
Total Outpatient Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the outpatient claims paid.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Patient Number	This is the unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This	Character	6

Field	Description	Data Type	Length
	might occur 23 times depending on the number of detail lines billed.		
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	Payee's state of residence.	Character	2
TPL Amount	This is the dollar amount paid by sources other than the medical assistance program being billed for the member's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Outpatient Claims Denied - Billed Amt	This amount reflects the total of all the outpatient claims billed for the provider.	Number	10
Total Outpatient Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Outpatient Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the provider's denied outpatient claim.	Number	10
Units	This shows the units of service rendered. These might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

TOTAL OUTPATIENT CLAIMS IN PROCESS: 99,999,999.99 99,999,999.99 9,999,999.99

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBS	This is the line level EOB. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	EOB codes.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2

Field	Description	Data Type	Length
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid by sources other than the medical assistance program being billed for the member's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Outpatient Claims In Process - Billed Amt	This amount reflects the total of all the outpatient claims billed for the provider.	Number	10
Total Outpatient Claims In Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Outpatient Claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the outpatient claims in process.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payees zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

99,999,999.99

9,999,999.99

99,999,999.99

Field	Description	Data Type	Length
Additional Payment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	The computed allowable dollar amount for claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Detail EOBs	These are the EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4

Field	Description	Data Type	Length
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. These might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
Paid Amount	The dollar amount that is payable for the claim.	Number	9
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. These might occur 23 times depending on the number of detail lines billed.	Number	3
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9

Field	Description	Data Type	Length
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	The state where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Total Outpatient Adjustment Claims - Allowed Amt	This amount reflects the allowed amount total of all the adjustment claims.	Number	10
Total Outpatient Adjustment Claims - Billed Amt	This amount reflects the total billed amount of all the adjustment claims.	Number	10
Total Outpatient Adjustment Claims - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the adjustment claims paid.	Number	9
Total Outpatient Adjustment Claims - Paid Amt	This amount reflects the total of all the adjustment claims paid.	Number	10
Total Outpatient Adjustment Claims - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the adjustment claims paid.	Number	10
Total Outpatient Adjustment Claims - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9

Field	Description	Data Type	Length
Total Outpatient Adjustment Claims - TPL Amt	This amount reflects the total of all TPL amounts for the adjustment claims paid.	Number	10
Units	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

MEDICARE CROSSOVER PART A CLAIMS PAID

Remittance Advice - Medicare Crossover Part A Claims Paid Report Layout

REPORT: CRA-0029-W	STATE OF OKLAHOMA										DATE: MMDDYY						
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM										PAGE: 9,999						
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE																
	MEDICARE CROSSOVER PART A CLAIMS PAID																
XX										PAYEE NUMBER	999999999 X						
XX										PAYMENT NUMBER	999999999						
XX										ISSUE DATE	MMDDYY						
XXXXXXXXXXXXXXXXXXXX, XX 99999-9999																	
--ICN--	SERVICE DATES		ADMIT	ATTENDING	SPENDDOWN	BLOOD	M E D I C A R E			M E D I C A I D							
PAT NO.	FROM	THRU	DAYS	DATE	PROVIDER	COPAY	AMT	DEDUCT	DEDUCT	CO-INS	BILLED	TPL	AMT	REIMB	AMT	PAID	
AMT																	
CLIENT NAME: XX CLIENT NO.: XXXXXXXXXXXXXXXX																	
	RRYYJJBBSS	MMDDYY	MMDDYY	999	MMDDYY	XXXXXXXXXX	999,999.99	999,999.99		999,999.99		9,999,999.99					
9,999,999.99	XX										999,999.99	999,999.99	9,999,999.99	9,999,999.99			
EOBS	00	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	01	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	02	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	03	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	04	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	05	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	
TOTAL MEDICARE CROSSOVER PART A CLAIMS PAID:							9,999,999.99	9,999,999.99		9,999,999.99		99,999,999.99					
9,999,999.99											9,999,999.99	9,999,999.99	99,999,999.99	99,999,999.99			

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the claim. There could be a maximum of 20 EOB codes. For detailed information on EOBs see HIPAA Reason Code.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable for the hospitalization stay.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	12

Field	Description	Data Type	Length
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claims Paid - Billed Amt	This amount reflects the total billed amount of the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claims Paid - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A claims paid.	Number	9
Total Medicare Crossover Part A Claims Paid - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part A claims paid, for the provider.	Number	9
Total Medicare Crossover Part A Claims Paid - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claims paid.	Number	9
Total Medicare Crossover Part A Claims Paid - Deductible	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claims paid.	Number	9
Total Medicare Crossover Part A Claims Paid - Paid Amt	This amount reflects the total of all the Medicare Crossover Part A claims paid.	Number	10
Total Medicare Crossover Part A Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part A claims paid.	Number	10
Total Medicare Crossover Part A Claims Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claims paid.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

MEDICARE CROSSOVER PART A CLAIMS DENIED

Remittance Advice - Medicare Crossover Part A Claims Denied Report Layout

REPORT: CRA-0030-W	STATE OF OKLAHOMA										DATE: MMDDYY
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM										PAGE: 9,999
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE										
	MEDICARE CROSSOVER PART A CLAIMS DENIED										
XX										PAYEE NUMBER 999999999 X	
XX										PAYMENT NUMBER 999999999	
XX										ISSUE DATE MMDDYY	
XXXXXXXXXXXXXXXXXXXX, XX 99999-9999											
--ICN--	SERVICE DATES		ADMIT	ATTENDING	SPENDDOWN	BLOOD	M E D I C A R E			M E D I C A I D	
PAT NO.	FROM	THRU	DAYS	DATE	PROVIDER	DEDUCT	DEDUCT	CO-INS	BILLED	TPL AMT	
CLIENT NAME: XX CLIENT NO.: XXXXXXXXXXXXXXXX											
	RYYJJBBSSS	MMDDYY	MMDDYY	999	MMDDYY	XXXXXXXXXX	999,999.99	999,999.99	999,999.99	9,999,999.99	9,999,999.99
XX										999,999.99	9,999,999.99
EOBS	00	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
	01	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
	02	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
	03	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
	04	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
	05	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
TOTAL MEDICARE CROSSOVER PART A CLAIMS DENIED:							9,999,999.99	9,999,999.99	9,999,999.99	99,999,999.99	99,999,999.99
								9,999,999.99		99,999,999.99	

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the claim. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	A one-byte alphabetic code used to indicate the location of the billing provider.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claims Denied - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claims Denied - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A Claims Denied.	Number	9
Total Medicare Crossover Part A Claims Denied - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claims denied.	Number	9
Total Medicare Crossover Part A Claims Denied - Deductible	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claims denied.	Number	10
Total Medicare Crossover Part A Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claims denied.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the claim. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid TPL Amount	Indicates payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	This indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	A one-byte alphabetic code used to indicate the location of the billing provider.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claims in Process - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claims in Process - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A claims in process.	Number	9
Total Medicare Crossover Part A Claims in Process - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claims in process.	Number	9
Total Medicare Crossover Part A Claims in Process - Deductible	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claims in process.	Number	9
Total Medicare Crossover Part A Claims in Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claims in Process - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claims in process.	Number	10
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

MEDICARE CROSSOVER PART A CLAIM ADJUSTMENTS

Remittance Advice - Medicare Crossover Part A Claim Adjustments Report Layout

REPORT: CRA-0032-W	STATE OF OKLAHOMA										DATE: MMDDYY					
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM										PAGE: 9,999					
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE															
	MEDICARE CROSSOVER PART A CLAIM ADJUSTMENTS															
XX										PAYEE NUMBER	999999999 X					
XX										PAYMENT NUMBER	999999999					
XX										ISSUE DATE	MMDDYY					
XXXXXXXXXXXXXXXXXXXX, XX 99999-9999																
--ICN--	SERVICE DATES	ADMIT	ATTENDING	SPENDDOWN	BLOOD	M E D I C A R E			M E D I C A I D							
PAT NO.	FROM	THRU	DAYS	DATE	PROVIDER	COPAY	AMT	DEDUCT	DEDUCT	CO-INS	BILLED	TPL	AMT	REIMB	AMT	PAID
AMT																
CLIENT NAME: XXX CLIENT NO.: XXXXXXXXXXXXXXX																
RYYJJBBBMMOM	MMDDYY	MMDDYY	999	MMDDYY	XXXXXXXXXXXX	(999,999.99)	(999,999.99)	(999,999.99)	(9,999,999.99)							
(9,999,999.99)																
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	(999,999.99)	(999,999.99)	(9,999,999.99)	(9,999,999.99)												
RYYJJBBBSSS	MMDDYY	MMDDYY	999	MMDDYY	XXXXXXXXXXXX	999,999.99	999,999.99	999,999.99	9,999,999.99							
9,999,999.99																
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999,999.99	999,999.99	9,999,999.99	9,999,999.99												
EOBS	00	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999
													ADDITIONAL PAYMENT	9,999,999.99		
													NET OVERPAYMENT	9,999,999.99		
													REFUND AMOUNT APPLIED	9,999,999.99		
TOTAL NO. OF ADJ: 999,999																
TOTAL MEDICARE CROSSOVER PART A ADJUSTMENT CLAIMS: 9,999,999.99 9,999,999.99 9,999,999.99 99,999,999.99																
99,999,999.99 9,999,999.99 9,999,999.99 99,999,999.99																

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Attending Provider	Number used to identify provider performing the service.	Number	10
Blood Deductible Amount	Amount that is paid toward a Medicare claim for blood deductible.	Number	8
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill. For example, some pharmacy programs require that the patient pay a specific amount toward each prescription filled. The fee will not be charged for the following members: individuals under 21, or members in nursing facilities and intermediate care facilities for the mentally retarded.	Number	8
Days	Total days member was in hospital.	Number	3
EOB Sequence Number	This is the sequential line number of the EOB code line.	Number	2
EOBS	These are the EOB codes that apply to the adjusted claim. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
Medicaid Billed Amount	The dollar amount billed by the provider for the hospitalization stay.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable for the hospitalization stay.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9

Field	Description	Data Type	Length
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare CO-Insurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an account receivable (setup) transaction is established.	Number	9
PAT NO	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Service Dates - From	This is the earliest date of service or the admit date.	Character	6
Service Dates - Thru	This is the latest date of service or discharge date.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
Total Medicare Crossover Part A Claim Adjustments - Billed Amt	This amount reflects the total billed amount of the Medicare Crossover Part A claims.	Number	10
Total Medicare Crossover Part A Claim Adjustments - Blood Deductible	This amount reflects the total of all blood deductible amounts for the Medicare Crossover Part A claim adjustments.	Number	9

Field	Description	Data Type	Length
Total Medicare Crossover Part A Claim Adjustments - Co-Pay Amt	This amount reflects the total of all co-pay amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Co-insurance Amt	This amount reflects the total of all co-insurance amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Deductibles	This amount reflects the total of all deductible amounts for the Medicare Crossover Part A claim adjustments.	Number	9
Total Medicare Crossover Part A Claim Adjustments - Paid Amt	This amount reflects the total of all the Medicare Crossover Part A claim adjustments.	Number	10
Total Medicare Crossover Part A Claim Adjustments - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Medicare Crossover Part A Claim Adjustments - TPL Amt	This amount reflects the total of all TPL amounts for the Medicare Crossover Part A claim adjustments.	Number	10
Total Medicare Crossover Part A Claims Adjustments - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Medicare Crossover Part A claims.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed Amount	This is the computed allowable amount for the services billed.	Number	9
Attend Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This indicates level of care rendered for patient.	Character	3
Paid Amount	This is the dollar amount that is payable for the member's stay.	Number	9
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9

Field	Description	Data Type	Length
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Long Term Care Claims Paid - Allowed Amt	This amount reflects the allowed amount total of all the Long Term Care claims paid.	Number	10
Total Long Term Care Claims Paid - Billed Amt	This amount reflects the total billed amount of the Long Term Care claims.	Number	10
Total Long Term Care Claims Paid - Paid Amt	This amount reflects the total of all the Long Term Care claims paid.	Number	10
Total Long Term Care Claims Paid - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims paid.	Number	9
Total Long Term Care Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Long Term Care claims paid.	Number	10
Total Long Term Care Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims paid.	Number	10
Units	This is the number of units of service.	Number	8

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Attend Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This indicates level of care rendered for patient.	Character	3
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9

Field	Description	Data Type	Length
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Long Term Care Claims Denied - Billed Amt	This amount reflects the total billed amount of all the Long Term Care claims.	Number	10
Total Long Term Care Claims Denied - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims denied.	Number	9
Total Long Term Care Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims denied.	Number	10
Units	This is the number of units of service.	Number	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

LONG TERM CARE CLAIMS IN PROCESS

Remittance Advice - Long Term Care Claims In Process Report Layout

REPORT: CRA-0035-W	STATE OF OKLAHOMA		DATE: MMDDYY			
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM		PAGE: 9,999			
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE					
	LONG TERM CARE FACILITY CLAIMS IN PROCESS					
XX			PAYEE NUMBER 999999999 X			
XX			PAYMENT NUMBER 999999999			
XX			ISSUE DATE MMDDYY			
XXXXXXXXXXXXXXXXXXXX, XX 99999-9999						
--ICN--	ATTEND PROV.	SERVICE DATES	BILLED	TPL	PATIENT	
--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT	LIABILITY	
CLIENT NAME: XXX	CLIENT NO.: XXXXXXXXXXXXXXX					
RRYYJJBBSSS XXXXXXXXX	MMDDYY MMDDYY 999		9,999,999.99	9,999,999.99	999,999.99	
XX						
HEADER EOB:	9999 9999					
REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOB
999	XXXXXX	MMDDYY	999	999999.99	9,999,999.99	9999 9999
999	XXXXXX	MMDDYY	999	999999.99	9,999,999.99	9999 9999
999	XXXXXX	MMDDYY	999	999999.99	9,999,999.99	9999 9999
999	XXXXXX	MMDDYY	999	999999.99	9,999,999.99	9999 9999
TOTAL LONG TERM CARE FACILITY CLAIMS IN PROCESS:				99,999,999.99	99,999,999.99	9,999,999.99

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	The first name of the client.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	This indicates level of care rendered for patient.	Character	3
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	This unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50

Field	Description	Data Type	Length
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
TPL Amount	Dollar amount paid by sources other than medical assistance program being billed for the member's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Total Long Term Care Claims In Process - Billed Amt	This amount reflects the total billed amount of the Long Term Care Claims.	Number	10
Total Long Term Care Claims In Process - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims in process.	Number	9
Total Long Term Care Claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims in process.	Number	10
Units	This is the number of units of service.	Number	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	This is the computed allowable amount for the services billed. The data displayed pertain to the adjusted claim.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount requested by the provider for the service billed on the detail line. This Might occur 23 times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Days	This is the number of days the member was in the nursing home.	Number	3
Detail EOBS	These are the EOB codes that apply to the claim detail lines. These codes are used to explain why the claim was adjusted. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Character	4
HCPCS/Rate	This is the billed rate for the revenue code billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	Unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10
LVL Care	Indicates level of care rendered for patient.	Character	3
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9

Field	Description	Data Type	Length
Paid Amount	This is the dollar amount that is payable for the member's stay.	Number	9
Patient Liability	This is the patient liability amount that the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	8
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	This shows the revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes. The data displayed pertain to the adjusted claim.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2

Field	Description	Data Type	Length
TPL Amount	This is the dollar amount paid for the services by any source outside of the state Medical Assistance program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total Long Term Care Claims ADJ - Allowed Amt	This amount reflects the allowed amount total of all the Long Term Care claims adjustments.	Number	10
Total Long Term Care Claims ADJ - Billed Amt	This amount reflects the total billed amount of all the Medicare Crossover Part A claims.	Number	10
Total Long Term Care Claims ADJ - Paid Amt	This amount reflects the total of all the Long Term Care claims adjustments.	Number	10
Total Long Term Care Claims ADJ - Patient Liability	This amount reflects the total of Patient Liability amounts for all the Long Term Care claims adjustments.	Number	9
Total Long Term Care Claims ADJ - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Long Term Care claims adjustments.	Number	10
Total Long Term Care Claims ADJ - TPL Amt	This amount reflects the total of all TPL amounts for the Long Term Care claims adjustments.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Units	This is the number of units of service.	Number	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Allowed Amount	This is the computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. Adding all the allowable amounts for all the services described on the detail lines arrives at this amount.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	This is the dollar amount billed by the provider for the services rendered.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	Dollar amount that member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Detail EOBS	These are the EOB codes that apply to the claim detail lines. These codes are used to explain why the claim was denied. There could be a maximum of 20 EOB codes per detail line. See HIPAA Reason Code for detailed information on EOBs.	Number	4
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	These are the EOB codes that apply to the claim header. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Paid Amount	This is the dollar amount that is payable for the services rendered. This represents the allowable amount plus the overhead amount, minus the TPL and deductible amounts.	Number	9

Field	Description	Data Type	Length
Patient Number	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
REV CD	These are the revenue codes that pertain to the services being billed on the detail lines. This might occur 23 times depending on the number of detail lines billed.	Number	3
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. This might occur 23 times depending on the number of detail lines billed.	Character	6
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state Medical Assistance Programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Total Home Health Claims Paid - Allowed Amt	This amount reflects the allowed amount total of all the Home Health Claims paid.	Number	10
Total Home Health Claims Paid - Billed Amt	This amount reflects the total billed amount of all the Home Health claims.	Number	10
Total Home Health Claims Paid - Co-Pay	This amount reflects the total of co-pay amounts for all the Home Health claims paid.	Number	9
Total Home Health Claims Paid - Paid Amt	This amount reflects the total of all the Home Health claims paid.	Number	10
Total Home Health Claims Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the Home Health claims paid.	Number	10

Field	Description	Data Type	Length
Total Home Health Claims Paid Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Home Health Claims Paid - TPL Amt	This amount reflects the total of all TPL amounts for the Home Health claims paid.	Number	10
Units	This shows the units of service rendered on the claim. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	This is the total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBS	These are the EOB codes that apply to each detail line on the claim form. See HIPAA Reason Code for detailed information on EOBs.	Character	4
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Character	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur six times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur six times depending on the number of detail lines billed.	Character	5
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state Medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Total CMS-1500 Claims Denied - Billed Amt	This amount reflects the total billed amount of all the CMS-1500 claims.	Number	10
Total CMS-1500 Claims Denied - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total CMS-1500 Claims Denied - TPL Amt	This amount reflects the total of all TPL amounts for the CMS-1500 claims denied.	Number	10
Units	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Billed Amount	This is the total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Detail EOBS	These are the EOB codes that apply to each detail line on the claim form. See HIPAA Reason Code for detailed information on EOBs.	Character	4
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Character	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
Issue Date	Date check was issued.	Character	10
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur six times depending on the number of detail lines billed.	Character	2
PROC CD	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur six times depending on the number of detail lines billed.	Character	5
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Rendering Provider Number	Number used to identify provider performing the service.	Number	9

Field	Description	Data Type	Length
Service Dates - From	This is the earliest date of service on all the detail lines.	Character	6
Service Dates - Thru	This is the latest date of service on all the detail lines.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	Payments made by sources outside of the state Medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Total CMS-1500 Claims In Process - Billed Amt	This amount reflects the total billed amount of all the CMS-1500 claims.	Number	10
Total CMS-1500 Claims In Process - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total CMS-1500 Claims In Process - TPL Amt	This amount reflects the total of all TPL amounts for the CMS-1500 claims in process.	Number	10
Units	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

CMS-1500 CLAIM ADJUSTMENTS

Remittance Advice - CMS-1500 Claim Adjustments Report Layout

REPORT: CRA-0116-W	STATE OF OKLAHOMA		DATE: MMDDYY						
PROCESS: FNIO3011	MEDICAID MANAGEMENT INFORMATION SYSTEM		PAGE: 9,999						
LOCATION: FINJW201	PROVIDER REMITTANCE ADVICE								
	CMS 1500 CLAIM ADJUSTMENTS								
XX			PAYEE NUMBER 999999999						
XX			PAYMENT NUMBER 999999999						
XX			ISSUE DATE MMDDYY						
XXXXXXXXXXXXXXXXXX, XX 99999-9999									
--ICN--	SERVICE DATES	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	REIMB.	PAID	
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: 999999999999									
RYYJJBBSS	MMDDYY MMDDYY	(9,999,999.99)		(9,999,999.99)		(999,999.99)		(9,999,999.99)	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			(9,999,999.99)		(999,999.99)		(9,999,999.99)		
RYYJJBBSS	MMDDYY MMDDYY	9,999,999.99		9,999,999.99		999,999.99		9,999,999.99	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			9,999,999.99		999,999.99		9,999,999.99		
HEADER EOB: 9999									
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL EOB	
XX	XXXXXX	XX XX XX XX	9999.99	MMDDYY MMDDYY	XXXXXXXXXX	9,999,999.99	9,999,999.99	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX	XXXXXX	XX XX XX XX	9999.99	MMDDYY MMDDYY	XXXXXXXXXX	9,999,999.99	9,999,999.99	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX	XXXXXX	XX XX XX XX	9999.99	MMDDYY MMDDYY	XXXXXXXXXX	9,999,999.99	9,999,999.99	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX	XXXXXX	XX XX XX XX	9999.99	MMDDYY MMDDYY	XXXXXXXXXX	9,999,999.99	9,999,999.99	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX	XXXXXX	XX XX XX XX	9999.99	MMDDYY MMDDYY	XXXXXXXXXX	9,999,999.99	9,999,999.99	9999	9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
								ADDITIONAL PAYMENT	9,999,999.99
								NET OVERPAYMENT	9,999,999.99
								REFUND AMOUNT APPLIED	9,999,999.99
TOTAL NO. OF ADJ: 999,999									
TOTAL CMS 1500 ADJUSTMENT CLAIMS: 99,999,999.99 99,999,999.99 9,999,999.99 99,999,999.99									

Field	Description	Data Type	Length
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Allowed Amount	This is the computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. Adding all the allowable amounts for all the services described on the detail lines arrives at this amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Billed Amount	This is the total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detail lines arrives this at. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
City	City where payee resides.	Character	15
Client Number	Member's Medicaid identification number.	Character	12
Client Name	Client's name.	Character	29
Co-Pay Amount	The dollar amount that the member should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	8
Detail EOBS	These are the EOB codes that apply to each detail line on the claim form. See HIPAA Reason Code for detailed information on EOBs.	Character	4
Header EOBS	These are the EOB codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of 20 EOB codes. See HIPAA Reason Code for detailed information on EOBs.	Character	4
ICN	This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check was issued.	Character	10

Field	Description	Data Type	Length
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
Net Overpayment	This provides the net overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established.	Number	9
PL SERV	This column shows the place of service code(s) indicating where the services were actually rendered. May occur six times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Character	2
PROC CD	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur six times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Character	5
Paid Amount	This is the dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the TPL amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Patient Number	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Character	30
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Refund Amount Applied	This provides the refund amount applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
Service Dates - From	This is the earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6

Field	Description	Data Type	Length
Service Dates - Thru	This is the latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
State	State where payee resides.	Character	2
TPL Amount	This is the dollar amount paid for the services by any source outside of the state Medical Assistance program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total CMS-1500 Claims Adj Paid - Allowed Amt	This amount reflects the allowed amount total of all the CMS-1500 claims adjustments paid.	Number	10
Total CMS-1500 Claims Adj Paid - Billed Amt	This amount reflects the total billed amount of all the CMS- 1500 claims.	Number	10
Total CMS-1500 Claims Adj Paid - Co-Pay Amt	This amount reflects the total of Co-pay amounts for all the CMS-1500 claims adjustments paid.	Number	9
Total CMS-1500 Claims Adj Paid - Paid Amt	This amount reflects the total of all the CMS-1500 claims adjustments paid.	Number	10
Total CMS-1500 Claims Adj Paid - Reimbursement Amt	This amount reflects the total of all reimbursement amounts for the CMS-1500 Claims Adjustments Paid.	Number	10
Total CMS-1500 Claims Adj Paid - Spenddown Amt	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total CMS-1500 Claims Adj Paid - TPL Amt	This amount reflects the total of all TPL amounts for the CMS-1500 claims adjustments paid.	Number	10
Total No. Adj	This is the total number of claims adjusted for the current financial cycle.	Number	6
Units	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed. The data displayed pertain to the adjusted claim.	Number	6
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

Remittance Advice Summary Report Layout

REPORT: CRA-0148-W
 PROCESS: FNIO3011
 LOCATION: FINJW201

STATE OF OKLAHOMA
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 SUMMARY

DATE: MMDDYY
 PAGE: 9,999

XX
 XXX
 XXX
 XXXXXXXXXXXXXXXXXXX, XX 99999-9999

PAYEE NUMBER 999999999 X
 PAYMENT NUMBER 999999999
 ISSUE DATE MMDDYY

-----CLAIMS DATA-----

	CURRENT NUMBER	CURRENT AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	999,999	9,999,999.99	9,999,999	99,999,999.99
CLAIM ADJUSTMENTS	999,999	9,999,999.99	9,999,999	99,999,999.99
TOTAL CLAIMS PAYMENTS	999,999	9,999,999.99	9,999,999	99,999,999.99
CLAIMS DENIED	999,999		9,999,999	
CLAIMS IN PROCESS	999,999		9,999,999	

-----EARNINGS DATA-----

PAYMENTS:				
REIMBURSEMENT AMOUNT		9,999,999.99		99,999,999.99
STATE SHARE AMOUNT		(9,999,999.99)		(99,999,999.99)
CLAIMS PAYMENTS		9,999,999.99		99,999,999.99
CAPITATION PAYMENT†		9,999,999.99		99,999,999.99
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)		9,999,999.99		99,999,999.99
ACCOUNTS RECEIVABLE (OFFSETS):				
CLAIM SPECIFIC:				
CURRENT CYCLE		(9,999,999.99)		(99,999,999.99)
OUTSTANDING FROM PREVIOUS CYCLES		(9,999,999.99)		(99,999,999.99)
NON-CLAIM SPECIFIC OFFSETS		(9,999,999.99)		(99,999,999.99)
NET PAYMENT**		9,999,999.99		99,999,999.99
REFUNDS:				
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(9,999,999.99)		(99,999,999.99)
NON CLAIM SPECIFIC REFUNDS		(9,999,999.99)		(99,999,999.99)
OTHER FINANCIAL:				
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)		9,999,999.99		99,999,999.99
VOIDS		(9,999,999.99)		(99,999,999.99)
NET EARNINGS		9,999,999.99		99,999,999.99
FICA WITHHELD		9,999,999.99		99,999,999.99

** NET PAYMENT AMOUNT HAS BEEN REDUCED. LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS.

† CAPITATION PAYMENT FOR THE MONTH OF MM/YY. PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.

Field	Description	Data Type	Length
Address	Payee's address.	Character	31
Check/EFT Number	This is the check number corresponding to a check or the control number of an EFT transaction.	Number	9
City	City where payee resides.	Character	15
Current Amount Capitation Payment	The total dollar amount of the capitation payment for the current month. This dollar amount will only be reported on the first financial cycle of every month. In addition, this number will be reported on the RA only for those providers receiving administrative payments during the current year.	Number	9
Current Amount Claim Adjustments	The total net dollar amount of all positive adjustments finalized during the current financial cycle. Negative adjustments that result in an A/R are reported below in the offsets section. Refund adjustments are reported in the Refunds section of the RA.	Number	9
Current Amount Claim Specific A/R (Offsets Current Cycle)	The total dollar amount of all claim specific A/R established during the current financial cycle.	Number	9
Current Amount Claim Specific Adjustment Refunds	The sum dollar amount of all claim specific refunds received and applied during the current weekly financial cycle.	Number	9
Current Amount Claims Paid	The total dollar amount of the claims paid during the current weekly financial cycle.	Number	9
Current Amount Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized from the current weekly financial cycle. This number is propagated from the Total Claims Payment field of the Claims Data section.	Number	9
Current Amount FICA Withheld	This is the amount of FICA withheld for certain provider types for the current period.	Number	9
Current Amount Lien Holder Payment	The total dollar amount that is being paid to the lien holder during the current weekly financial cycle. If there is more than one lien holder, each lien will be printed separately.	Number	9
Current Amount Manual Payouts (Non Claim Specific)	Manual payouts entered into the system during the current financial cycle. This only includes those checks that were issued outside the system through a manual checkwrite versus a system payout that is issued through the system.	Number	9
Current Amount Net Earnings	Calculates the net earnings for the current weekly financial cycle. Calculation is as follows: Payments and manual payouts less offsets, refunds and voids.	Number	9

Field	Description	Data Type	Length
Current Amount Net Payment	The sum of all claims payments less any offsets for the current financial cycle. This amount will equal the provider's weekly payment and the provider's checkwrite. NOTE: If a lien has been assessed against a provider's payments, this number will still represent the total net payment for the provider, but the checkwrite will be the payment less any lien payment amounts. A double asterisk (**) next to the net payment amount denotes that the actual check amount will be reduced by a lien assessed against a provider's payments.	Number	9
Current Amount Non Claim Specific Offsets	The total dollar amount of all non-claim specific accounts receivables established during the current financial cycle.	Number	9
Current Amount Non Claim Specific Refunds	The sum dollar amount of all non-claim specific refunds received and applied during the current weekly financial cycle.	Number	9
Current Amount Outstanding A/R from Prev Cycles	The dollar amount of all claim specific A/R established in previous cycles which have not been satisfied.	Number	9
Current Amount State Share Amount	This is the amount of state share (a negative amount) for the current period.	Number	9
Current Amount System Payouts (Non Claim Specific)	The total dollar amount of all non-claim specific payouts made to the provider for the current financial cycle.	Number	9
Current Amount Total Claims Payments	The total dollar amount of all claims paid and the net dollar amount of all positive adjustments finalized during the current weekly cycle.	Number	9
Current Amount Voids	The total dollar amount of all EDS issued checks that were voided during the current weekly financial cycle.	Number	9
Current Number Claim Adjustments	Net dollar amount of all positive adjustments finalized during the current financial cycle. Negative adjustments that result in an A/R are reported below in the offsets section. Refund adjustments are reported in the Refunds section of the RA.	Number	6
Current Number Claims Denied	The total number of claims denied during the current financial cycle.	Number	6
Current Number Claims Paid	The total number of claims paid during the current weekly financial cycle.	Number	6
Current Number Claims in Process	The total number of claims in process during the current weekly financial cycle.	Number	6
Current Number Total Claims Payments	The total number of claims paid and adjustments finalized during the current weekly financial cycle.	Number	6
Issue Date	Date check was issued.	Character	10

Field	Description	Data Type	Length
Lien Holder Name	Prints the name of the lien holder if a lien has been assessed against a provider's payments.	Number	39
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	If a check was generated to the billing provider for this week's cycle, this is the check number corresponding to the check that was generated. If the provider is an EFT participant, this is the control number of the EFT transaction.	Number	9
Provider Name	Payee's name	Character	50
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
State	State where payee resides.	Character	2
Y-T-D Amount Capitation Payment	The total dollar amount of the capitation payment year to date. This number will be reported on the RA only for those providers who have received admin payments during the current year.	Number	10
Y-T-D Amount Claim Specific A/R (Offsets Current Cycle)	The total dollar amount of all current cycle claim specific A/R established year to date. This will be equal to the current cycle amount. Accumulated year to date totals for claims specific offsets will be reported in the previous cycle A/R year to date field.	Number	10
Y-T-D Amount Claim Specific Adjustment Refunds	The sum dollar amount of all claims specific refunds received and applied year to date.	Number	10
Y-T-D Amount Claims Adjustments	Net dollar amount of all positive adjustments finalized year to date negative and refund adjustments are reported elsewhere on the RA.	Number	10
Y-T-D Amount Claims Paid	The total dollar amount of claims paid year to date.	Number	10
Y-T-D Amount Claims Payments	The total dollar amount of all claims paid and the net dollar amount of all positive adjustments finalized year to date.	Number	10
Y-T-D Amount FICA Withheld	This is the amount of FICA withheld for the year-to-date for certain provider types.	Number	10
Y-T-D Amount Lien Holder Payment	The total dollar amount that has been paid to the lien holder year to date.	Number	10
Y-T-D Amount Manual Payouts (Non Claim Specific)	Manual payouts issued year to date.	Number	10
Y-T-D Amount Net Earnings	Calculates the net earnings year to date (calculation is the same as above).	Number	10
Y-T-D Amount Net Payment	The sum of all claims payments less any offsets year to date.	Number	10

Field	Description	Data Type	Length
Y-T-D Amount Non Claim Specific Refunds	The sum dollar amount of all non-claim specific refunds received and applied year to date.	Number	10
Y-T-D Amount Non-Claim Specific Offsets	The total dollar amount of all non-claim specific A/Rs established year to date.	Number	10
Y-T-D Amount Outstanding A/R from Prev Cycles	The total dollar amount of all claim specific A/Rs established year to date.	Number	10
Y-T-D Amount State Share Amount	This is the amount of state share (a negative amount) for year-to-date.	Number	10
Y-T-D Amount System Payouts (Non-Claim Specific)	The total dollar amount of all non-claim specific payouts made to the provider year to date.	Number	10
Y-T-D Amount Total Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized year to date. This number is propagated from the Total Claims Payment field of the Claims Data section.	Number	10
Y-T-D Amount Voids	The total dollar amount of all voids for year.	Number	10
Y-T-D Number Claims Adjustments	The total number of adjustments finalized year to date.	Number	7
Y-T-D Number Claims Denied	The total number of claims denied year to date.	Number	7
Y-T-D Number Claims In Process	The total number of claims in process year to date.	Number	7
Y-T-D Number Claims Paid	The total number of claims paid year to date.	Number	7
Y-T-D Number Total Claims Payments	The total number of claims paid and adjustments finalized year to date.	Number	7
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

SECTION C: ELECTRONIC REMITTANCE ADVICE

An electronic RA is available by using the X12 835 transaction as mandated under HIPAA. The 835 transaction is available to all OHCA providers and contracted trading partners that have requested electronic RAs. The 835 is a financial transaction that functions as an electronic means of posting accounts receivable.

The 835 Transaction is available from the Web or Remote Access Server (RAS) in a downloadable file.

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. Oklahoma Medicaid will be providing a supplemental transaction that will provide claim status information on pended claims. This transaction is the 277pc Health Care Payer Unsolicited Claim Status.

SECTION D: 1099 & W-2s

Annual earnings, based on the unique Tax Identification Number (TIN), are reported on IRS Form 1099 and submitted to each provider and the Internal Revenue Service. All money earned by TIN is reported on the Form 1099, based on an untaxed basis. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.

Additionally, an IRS Form W-2 is generated to report earnings and FICA contributions to the OCHA's Individual Personal Care Services providers. All money earned and FICA withholdings for each of these providers is reported on the Form W-2. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.

SECTION E: STOP PAYMENTS, VOIDS, RE-ISSUANCE

Stop Payments

Stop Payments occur when a provider indicates a check was not received. If the provider has not received a check, a stop payment request is necessary so that a replacement check can be issued. If a check is incorrectly issued, the stop payment request is necessary to prevent the funds from being disbursed in error.

A provider may call to request that a stop payment be placed on a check that was not received. In order for a payment to be reissued, the original check must first be stopped in the OKMMIS, and the OHCA manually reissues the provider a system-generated replacement check. The check can be resubmitted anytime and will be printed in the next manual check print run.

Check Voids

There are two types of voids that can occur within the OKMMIS: regular check voids and check void/reissue

Regular Check Voids

The first type, a regular void, occurs for any of the following reasons:

- The individual receiving treatment, listed on the RA, is not a patient of the provider who received the check.
- A payment was received by the wrong provider, and the check is returned to the OHCA with “void” or “not ours” written on the face of the check.
- A check was paid to a provider who does not belong to the group or has left the group.
- The payment was inappropriately made payable to the wrong location or provider identification number.
- The check is cancelled by statute and the OHCA directs that a void can be completed.

In the above situations, the checks would be voided within the OKMMIS and all claims associated with the dollars identified to this check will become denied claims. In order to receive payment for any of the now voided claims, it will be necessary for the provider to resubmit the claims.

Check Void/Reissue

The second type of voided check is a Void/Reissue. Void/Reissue items are a result of a check being mutilated or destroyed and a subsequent reissued check being manually prepared.

SECTION F: ELECTRONIC CARE COORDINATION PAYMENTS

The 820 Transaction Set is the HIPAA compliant financial transaction used to transmit care coordination payments. The 820 Transaction Set is generated by the Oklahoma OKMMIS and is

distributed to primary care providers/case managers (PCP/CMs) who request electronic capitation reports and participate in the SoonerCare Choice program.

The 820 Care Coordination Payment is combined with the last financial cycle of the month. This transaction is used for the Premium Payment Remittance Information (PPRI).

Total payment amount noted in the BPR02 segment of the 820 Transaction may or may not equal the actual payment amount. This is due to the integration of the premium payment with fee-for-service claims payment in the same weekly financial cycle.

The 820 Transaction is only available by download via the Web or RAS. The PCP/CMs must contact EDS to make other arrangements if other media is required.

Appendices

- Banner Page
- CMS-1500 Claims Paid Page
- CMS-1500 Claims Denied Page
- CMS-1500 Claims In Process Page
- CMS-1500 Claim Adjustments Page
- Provider Remittance Advice Summary
- Explanation of Benefit Codes

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Chapter 17

Utilization Review



INTRODUCTION

Utilization review activities required by the OHCA are accomplished through a series of monitoring systems developed to ensure that services are reasonable, medically necessary and of optimum quality and quantity. Members and providers are subject to utilization review. Utilization control procedures safeguard against

- Unnecessary care and services
- Inappropriate services and quality of care
- Inappropriate payment

Utilization Review Focus

Utilization review activities ensure the efficient and cost-effective administration of the OHCA by monitoring

- Billing and coding practices
- Medical necessity
- Level of care validations
- Quality of care
- Documentation
- Misuse
- Overuse
- Reasonableness of prior authorization (PA)
- Other administrative findings

Federal Regulations

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456 mandate that utilization review of the OHCA services provide methods and procedures to safeguard against unnecessary use of care and services.

These federal regulations also require that the OHCA be able to identify and, if warranted, refer cases of suspected fraud or abuse to the Medicaid Fraud Control Unit of the Office of the Oklahoma Attorney General for investigation and prosecution. Utilization review guards against unnecessary medical care and services, and ensures that payments are appropriate according to the coverage policies established by the OHCA.

Utilization Review Monitoring

The Surveillance and Utilization Review System (SURS) is used to help identify patterns of inappropriate care and services. Use of this system enables the OHCA to develop a comprehensive profile of any unusual pattern of practice and reveals suspected instances of fraud or abuse in the SoonerCare (Medicaid) program. The Utilization Review program is a useful tool in detecting the existence of any potential defects in the level of care or services provided under the SoonerCare program.

SECTION A: PROVIDER UTILIZATION REVIEW

Fraud Defined

Fraud is an intentional deception or misrepresentation made by the provider or member, which could result in an unauthorized benefit such as an improper payment to a SoonerCare provider. Some examples of fraud are:

- Altering a member's medical records to generate fraudulent payments
- Billing for services or supplies not rendered or provided
- Soliciting, offering or receiving a kickback, bribe or rebate
- Submitting claim forms inappropriately altered to obtain higher reimbursement

Abuse Defined

The term abuse describes incidents or practices of the OHCA providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices can result in unnecessary costs to the OHCA, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. Some examples of abuse are:

- Billing and receiving payment from an OHCA member for the difference between the provider charge and the OHCA reimbursement for the service
- Submitting claims for services not medically necessary in relation to a member's diagnosis
- Excessive charges for services or supplies
- Violation of any of the provisions of the provider agreement

Record Retention

For more information on record retention, go to www.okhca.org, select the More Options link from the Providers section (see Screen Sample 16.1), and then select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Sections 317:30-3-4.1 and 317:30-3-15. Specific provider policy sections may be referenced for any additional requests.



Screen Sample 16.1

SECTION B: MEMBER UTILIZATION REVIEW

When member utilization review identifies a member who might be using SoonerCare services more extensively than his/her peers, the member can be placed on a Lock-In/Restricted Services Program. Visit www.okhca.org, select the More Options link in the Providers section (see Screen Sample 16.1), and then select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-14 to obtain more information on member lock-in.

Identification of Lock-In Members

Restricted data are available from the following areas:

- Eligibility Verification System (EVS)/Automated Voice Response (AVR) at 800-767-3949 or 405-840-0650
- Swipe card device
- The SoonerCare Provider Portal

If the member is restricted, the EVS/AVR, SoonerCare Provider Portal or swipe-card device will list those restrictions. In addition to the restricted program guidelines, all other OHCA guidelines, such as prior authorization (PA) requirements, must be followed.

For questions about the Lock-In program, please contact the pharmacy help desk at 800 522-0114, *option 4*. The PHARM-16 (Pharmacy Lock-In Referral form) is located on the Pharmacy Forms page at www.okhca.org/provider/types/pharmacy/pharmacy_forms.asp

SECTION C: UTILIZATION REVIEW TRENDS

Fraud and abuse of the SoonerCare system costs taxpayers millions of dollars each year. Responsible Oklahomans need to work together to prevent fraud and abuse, and to ensure that the SoonerCare funds available are directed to those who truly deserve them.

The state relies on the health care provider community to be active participants in detecting, and deterring SoonerCare abuse and fraud. If abusive or fraudulent activities are suspected, providers are encouraged to contact one of the following offices:

Member Fraud

Department of Health and Human Services
The Office of Inspector General

Oklahoma City HOTLINE 800-784-5887
Tulsa HOTLINE 800-797-1780

Office of Inspector General (OIG) National Hotline

1-800-HHS-TIPS (800-447-8477)

Office of Inspector General

Department of Health and Human Services
Medicaid Fraud Control Unit
Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Provider Fraud

Office of Attorney General
2300 North Lincoln Blvd., Suite 112
Oklahoma City, OK 73105
Phone: 405-521-4274
Tulsa Office: 918-581-2885

Program Integrity & Accountability

Oklahoma Health Care Authority
4345 North Lincoln Blvd.
Oklahoma City, OK 73154-0299
Phone: 405-522-7421
FAX: 405-530-3246

SECTION D: ADMINISTRATIVE REVIEW AND APPEAL PROCESS

Criminal Penalties

Section 1909 of the Social Security Act provides criminal penalties for providers or members who make false statements or representations or intentionally conceal facts in order to receive payments or benefits. These penalties apply to kickbacks, bribes and rebates to refer or induce purchase of SoonerCare compensable services. The penalties also apply to individuals who knowingly and willfully charge members the difference between billed amounts and the amount allowed by SoonerCare.

Basis for Sanctions

The OHCA may sanction a medical provider who has an agreement with the OHCA. To obtain more information on sanctions, go to www.okhca.org, select the More Options link under the Providers section (see Screen Sample 16.1), and then scroll down and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to sections 317:30-3-18, and 317:30-3-19.

Appeals Procedures (excluding nursing homes and hospitals)

To obtain more information on appeals, go to www.okhca.org, select the More Options link in the Providers section (see Screen Sample 16.1), and then scroll down and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-20; 317:2-1-2.2 (Members appeals); 317:2-1-2.3 (other grievances).

Appeals Procedures for Long Term Care Nursing Facilities

To obtain more information on long term care facility appeals, go to www.okhca.org, select the More Options link in the Providers section (see Screen Sample 16.1), and then scroll down and the OHCA Rules link under Policies and Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-21.

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Chapter 18

Quality Assurance and Improvement



INTRODUCTION

The Quality Assurance and Improvement Department of the Oklahoma Health Care Authority (OHCA) coordinates the quality assurance evaluation and improvement processes for all OHCA medical programs. These functions are accomplished through ongoing monitoring and evaluation of SoonerCare services and implementation of improvement initiatives to help ensure that SoonerCare beneficiaries receive appropriate and high quality health care. This unit also coordinates the activities of the agency Quality Assurance Committee and provides technical support in developing and reporting federally required quality assurance/improvement activities of the agency. In addition, the Quality Assurance and Improvement Department maintains the Oklahoma Medicaid Management Information System (OKMMIS) reference file of procedure and diagnosis codes for each SoonerCare program.

The Quality Assurance and Improvement requirements of the OHCA are completed through a variety of monitoring and evaluation activities to ensure that the health care services provided to SoonerCare members meet quality standards as well as program requirements. Quality Assurance and Improvement activities include

- monitoring of utilization for the various SoonerCare programs;
- on-site provider audits for the evaluation of contract compliance;
- investigation of member and provider complaints;
- development and monitoring of quality improvement studies; and
- ongoing evaluation and maintenance of the integrity of the OKMMIS system.

SECTION A: PROVIDER UTILIZATION REVIEW

State Medicaid agencies are required by federal regulations to provide methods and procedures to safeguard against unnecessary utilization of care and services, and to assure efficiency, economy and quality of care. To meet the requirements of the federal regulations, the OHCA contracts with a Quality Improvement Organization (QIO) to conduct medical and utilization reviews. APS Healthcare Midwest serves as the contracted QIO for the

OHCA. The Quality Assurance and Improvement department provides oversight of the QIO contract and works with the contracted QIO.

Federal regulations and OHCA rules state that some Medicaid services are subject to utilization review by an external organization under contract with the OHCA. The QIO conducts a medical hospital random sample review on services provided to SoonerCare beneficiaries in the SoonerCare Traditional fee-for-service program. The purpose of the inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to SoonerCare beneficiaries. Federal regulations require medical services and/or records to be reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay by the contracted organization. In addition to inpatient review, The QIO conducts a random sample review of hospital outpatient observation services to ensure that these services meet specified guidelines.

The OHCA rules state that the QIO conducts the administrative process for the providers it reviews. The process conducted by the QIO is the only administrative remedy available to providers and the decision issued by the QIO is considered by the OHCA to be a final administrative decision. The final determination is not appealable to the OHCA for any further administrative review. Following the final determination on a utilization review, the OHCA will recoup the monies paid to the provider(s) associated with the review.

All inpatient and outpatient observation services are subject to QIO post-payment utilization review. These reviews are based on illness severity and treatment intensity. Hospitals and providers have the opportunity to present any and all documentation available to support the medical necessity of the provided services. If a denial determination is made by the QIO, a notice is issued to the facility, and attending physician advising them of the decision and the time frame for submitting a reconsideration request. Additional information submitted with the reconsideration request will be reviewed by the QIO and a final decision on the reconsideration will be made by the QIO within the specified time frame. The provider(s) will be notified of that decision. Once that process is finalized, the QIO notifies the OHCA of the decision. If the initial decision is upheld, the claim is processed for recoupment. If the review is denied and a refund from the hospital and physician is required, the SoonerCare member may not be billed for the denied services.

SECTION B: ON-SITE PROVIDER AUDITS

The staff of the OHCA Quality Assurance and Improvement department conducts on-site provider audits on a routine basis for all SoonerCare Choice primary care providers. The purpose of these reviews is to assess contract compliance, and provide education to providers on the SoonerCare program, contract requirements, billing, EPSDT requirements, chart documentation and other topics. The unit staff provides information related to current performance improvement initiatives of the organization and referral assistance to other departments within the agency. The compliance team consists of a compliance analyst and a nurse who collaborates the required review items. Prior to the review, a departmental staff member notifies the office staff and provider of the upcoming review. Once a review date is scheduled, the staff mails a copy of the audit tool to the provider, including information about the documents requested for the review. A list of the requested medical records will be submitted to the provider prior to the review. Following the on-site review, the provider receives a written audit report that details the findings and any required follow-up action. The QA/QI staff will work with the provider to comply with any required action. The compliance team works in partnership with the contracted provider and other OHCA staff and is available to assist with improvement activities.

SECTION C: MEMBER OR PROVIDER COMPLAINTS

Quality Assurance and Improvement staff members conduct reviews and follow-ups for member's and provider's potential quality of care issues. These cases are identified by OHCA staff and are referred to the Quality Assurance and Improvement department for review. When a referral is received, it is often necessary to request records from provider(s) identified in the actual referral or through an analysis of claims related to the complaint.

Cases may also be identified by the contracted QIO through completion of activities associated with contract requirements. When identified, medical records and/or additional information from the identified provider are requested for completing the review of potential issues. OHCA staff may also refer potential quality of care cases to the QIO for review and follow-up.

SECTION D: QUALITY IMPROVEMENT STUDIES/PROJECTS

The OHCA conducts ongoing quality improvement studies. Some of these studies are ad hoc in nature and developed in response to an identified area of focus for improvement. Others are conducted on a routine and ongoing basis. In addition to the studies conducted in the unit, the OHCA conducts studies through its contract with its QIO.

A partial listing of studies conducted by OHCA staff and/or in collaboration with its QIO include

- EPSDT screenings;
- comprehensive diabetic management;
- ER utilization;
- cervical cancer screenings;
- breast cancer screenings;
- appropriate medications for the treatment of asthma;
- prenatal care;
- service utilization; and
- member satisfaction surveys.

The completion of some studies requires review of the medical records associated with the SoonerCare members selected in the sample. For those studies, a request for a copy of each medical record needed for review will be made by staff from the contracted QIO and/or by OHCA staff. Providers are required to send requested records within the request's specified time frame. The Quality Assurance and Improvement Department encourages any questions concerning the medical record requests.

The Quality Assurance and Improvement Department also develops and monitors quality improvement initiatives. Current initiatives include

- emergency room utilization provider profiling;
- emergency room utilization member outreach;
- adult diabetes care;
- EPSDT screenings;
- childhood immunizations; and
- adolescent immunizations.

The Quality Assurance and Improvement Department is currently developing additional provider profiles, which include breast cancer screening, cervical cancer screening and EPSDT screening.

In addition to internal improvement activities, the OHCA collaborates with external organizations in research and quality improvement initiatives. Department staff members are active project participants with the State Task Force to Reduce Health Care Disparities, the Child Death Review Board, the Center for Health Care Strategies and the Oklahoma State Department of Health. Departmental staff members also provide data and research support for multiple quality-related projects.

SECTION E: SYSTEM INTEGRITY

The Quality Assurance and Improvement Department maintains the OKMMIS Reference File, which includes diagnosis, procedure and revenue codes, and program specifications for claim processing. The department is also responsible for maintenance of the claims editing program, which is an integral part of the processing of physician claim form 1500. The staff members monitor and update code changes, existing policy, and policy changes to evaluate the impact of changes to the reference file and claims editing program. The department also makes recommendations for policy changes and/or new policy in response to program changes as well as changes throughout the health care industry.



Chapter 19

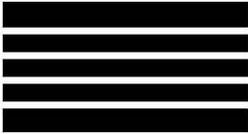
Forms

INTRODUCTION

Included in this chapter are copies of the forms mentioned in this manual. OHCA forms can also be obtained on the OHCA Web site at www.okhca.org/providers.aspx?id=120.

Form	Name
Pharm-1	Drug Claim Form
Pharm-2	Compound Prescription Drug Claim
Pharm -3	Pharmacy Paid Claim Adjustment Request
Pharm-4	Universal Petition for Medication Authorization
Pharm-6	Petition for Tuberculosis-Related Therapy Authorization
Pharm-7	Petition for Synagis Authorization
Pharm-8	Medication Therapy Management Services Prior Authorization Request
Pharm-9	Medication Therapy Management Services Member Referral Form
Pharm-11	Brand Name Drug Override Request
Pharm-14	Statement of Medical Necessity for Xolair
Pharm-6	Petition for Tuberculosis-Related Therapy Authorization
Pharm-16	Pharmacy Lock-in Referral
HCA-3	Elective Sterilization Consent
HCA-3A	Hysterectomy Acknowledgement
HCA-3B	Certificate for Abortion
HCA-12A	Prior Authorization Medical Request Form
HCA-12B	Prior Authorization Dental Request Form

HCA-13	Electronic Claim Paper Attachment Form Cover Sheet
HCA-13A	Prior Authorization Attachment Form Cover Sheet
HCA-14	UB-04 and Inpatient/Outpatient Crossover Adjustment Form
HCA-15	Paid Claim Adjustment Request for Crossover Part B, Dental, and 1500
HCA-17	Inquiry Response Form
HCA-18	Request for Duplicate Provider Remittance Statement (beyond 60 days)
HCA-20 English	Request to Release SoonerCare Records
HCA-20 Spanish	Autorización para reveler el expediente medico
HCA-24	Care Management Referral
HCA-28	Professional Services Medicare-Medicaid Crossover Invoice
UB-04	Institutional Claim Form
1500	Professional Claim Form
ADA 2012	Dental Claim Form
SC-10	SoonerCare Choice Referral Form with Guidelines and instructions
SC-16	SoonerCare Choice Provider Change Request



k

**State of Oklahoma
Oklahoma Health Care Authority
Prescription Drug Claim Form**

PLEASE PRINT CLEARLY

Provider Number (required) 01		Loc (req) 02	Billing NPI (optional) 03		Telephone Number 04	
Patient's Name: Last, First (required) 05		Member ID (Required) 06	Member's Date of Birth (Required mmddccyy) 07	Emergency (Y or N) 08	Pregnancy (Y or N) 09	NH Pt. (Y or N) 10
Prescription Number (Required) 11	Date Prescribed (Required) 12	Date Dispensed (Required) 13		NDC Number (Required) 14	Quantity (required) 15	Days 16
Brand Medically Necessary 17	Refill 18	Individual Prescriber's NPI Number (Required) 19		Individual Prescriber's Name: Last, First (Required) 20		
Provider's Name and Address 25		<p>This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.</p> <p>I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.</p>				
		Signature of Provider or Representative (Required) 26		Date Billed (Required) 27		
Charge (Required) 21	Third Party Paid 22	Total Amount Billed (Required) 23		Usual and Customary 24		

Mail Completed Claim Form to:
HPES
P.O. Box 18650
Oklahoma City, OK 73154

OKLA HCA Revised 02/07/2011

PHARM-1



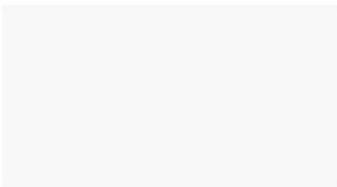
**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
Compound Prescription Drug Claim**

PLEASE PRINT CLEARLY

1 Provider Number		Loc	Telephone Number								
2 PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S ID NUMBER		EMERG	PREG	N.H. PAT	BRAND	REFILL
3 PRESCRIPTION NUMBER		DATE PRESCRIBED		4 DATE DISPENSED		5 LOCAL USE ONLY		DAYS		6 CHARGE	
7 LINE NUMBER		8 NDC NUMBER		9 DESCRIPTION OF INGREDIENT		10 CHARGE		11 3 RD PARTY PAID		12 QUANTITY	
13		14		15		16		17		18	
19		20		21		22		23		24	
25		26		27		28		29		30	
31		32		33		34		35		36	
37		38		39		40		41		42	
43		44		45		46		47		48	
49		50		51		52		53		54	
55		56		57		58		59		60	
61		62		63		64		65		66	
67		68		69		70		71		72	
73		74		75		76		77		78	
79		80		81		82		83		84	
85		86		87		88		89		90	
91		92		93		94		95		96	
97		98		99		100		101		102	

Provider's Name and Address

18



This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of
Provider or Representative

Date Billed

19

20

MAIL COMPLETED CLAIM FORM TO:

EDS
P.O. Box 18650
Oklahoma City, OK 73154

**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY PAID CLAIM ADJUSTMENT REQUEST**

List no more than 10 claims per request

<p>(1) PROVIDER NUMBER</p> <p>PROVIDER NAME/ADDRESS</p> <div style="background-color: #cccccc; height: 30px; width: 100%;"></div> <p>PHONE NUMBER:</p> <p>CONTACT PERSON:</p>	<p>Mail completed adjustment request forms to: OHCA – Adjustments 4345 N. Lincoln Blvd. Oklahoma City, OK 73105 Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299</p>
<p>(2) MEDICAID PROGRAM</p> <p><input type="checkbox"/> Fee for Service</p> <p><input type="checkbox"/> SoonerCare</p>	<p>(3) TYPE OF ADJUSTMENT</p> <p><input type="checkbox"/> Underpayment Adjustment</p> <p><input type="checkbox"/> Overpayment Adjustment (Deduct from future payments)</p> <p><input type="checkbox"/> Refund Adjustment (Check attached)</p> <p>Check number:</p>

Complete blocks 4 – 10 for each Pharmacy claim to be adjusted. If all information is not complete, this request will be returned.

(4) CLAIM NUMBER (ICN)	(5) CLIENT ID NO.	(6) DATE DISPENSED	(7) AMOUNT PAID	(8) CURRENT INFORMATION	(9) CORRECTED INFORMATION	(10) EXPLANATION OF ADJUSTMENT

(11) SIGNATURE: _____ **(12) DATE:** _____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY PAID CLAIM ADJUSTMENT REQUEST INSTRUCTIONS

A completed adjustment request form is required for each claim you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

- | | | |
|-----------|------------------------------|--|
| 1 | PROVIDER NUMBER | Enter your 9 digit billing provider number and 1 character service location |
| | PROVIDER NAME/ADDRESS | Enter your current billing name and address |
| | PHONE NUMBER | Enter phone number of contact person |
| | CONTACT NAME | Enter a contact name |
| 2 | PROGRAM | Check the appropriate box for the program to which the claim to be adjusted is associated |
| 3 | TYPE OF ADJUSTMENT | <p>Check the appropriate box for the type of adjustment you are requesting:</p> <p>* Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim’s data which will result in no net change in payment.</p> <p>* Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion or the entire amount of the claim.)</p> <p>* Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)</p> |
| 4 | CLAIM NUMBER (ICN) | Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (use the most current ICN for the claim to be adjusted.) |
| 5 | CLIENT ID NO. | Enter the recipient’s 12 digit identification number |
| 6 | DATE DISPENSED | Enter the Dispense Date as billed on the claim |
| 7 | AMOUNT PAID | Enter the Paid Amount of the claim to be adjusted |
| 8 | CURRENT INFO | Enter the information as stated on the current claim that is to be adjusted |
| 9 | CORRECTED INFO | Enter the corrected information for the claim |
| 10 | EXPLANATION | Give a clear explanation of the requested adjustment or refund (i.e. submitted incorrect units or service, incorrect NDC, private insurance paid) |
| 11 | SIGNATURE | Enter signature of appropriate person (physician, billing clerk, etc. – not required) |
| 12 | DATE | Enter the date you are submitting this request (Required) |



STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

PETITION FOR TUBERCULOSIS (TB) RELATED THERAPY
AUTHORIZATION

ONLY ONE INDIVIDUAL PER PETITION

Member Name: _____ Birthdate: [][]/[][]/[][][][]

Member ID: [][][][][][][][][][]

TO BE COMPLETED BY DISPENSING PHARMACY

Dispensing Pharmacy Name: _____

Dispensing Pharmacy NPI: [][][][][][][][][][]

Dispensing Pharmacy Phone Number: ([][][]) [][][] - [][][][] Dispensing Pharmacy Fax Number: ([][][]) [][][] - [][][][]

NDC Number: [][][][][] - [][][][][] - [][]

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Medication Name: _____

Dosage: _____ Qty Prescribed: _____

Has the patient been approved for TB benefits? Yes [] No []

Please list supporting information that associates this therapy with the patient's primary diagnosis of TB (use additional sheets if necessary):

Intent of the Program is to work with Health Care Providers. Therefore, if there are circumstances relating to the treatment of the individual that would warrant additional consideration, please provide appropriate comments on the additional page.

Signature of Prescribing Physician: _____

Name of Prescribing Physician (Please Print): _____

Prescribing Physician's Fax Number: ([][][]) [][][] - [][][][]

Prescribing Physician's NPI: [][][][][][][][][][]

Please Provide the Information Requested and Return to: UNIVERSITY OF OKLAHOMA
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS PRODUCT BASED PRIOR
AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4 Toll Free
800-522-0114 Opt 4
<http://www.okhca.org>
OHCA Revised 04/24/2014

FAX (405) 271-4014
Toll Free 800-224-4014

PHARM -6

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STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PETITION FOR SYNAGIS AUTHORIZATION

Member Name: _____ Sex: _____ ID #: _____
 Date of birth: _____ Gestational age: _____ weeks Current Age: _____ Months
 Birth Weight: _____ kg Current Weight: _____ kg Date Recorded: _____
 Dose received in hospital. Date: _____

DRUG INFORMATION: 15 mg/kg IM. Only those doses that require greater than a vial's dose +10% may use the next vial size or an additional vial (e.g. 1-55 mg = 50 mg vial, 56-110 mg = 100 mg vial). The maximum duration of therapy is 5 doses, each dose to be given every 30 days (infants 32-34 weeks gestation will receive a maximum of 3 doses).

Physician billing CPT code 90378 (50 mg/unit)

Pharmacy billing 50 mg/0.5 ml: NDC: **60574411401** 100 mg/ml: NDC: **60574411301**

PROVIDER INFORMATION: Pharmacy Physician

Provider _____ Provider NPI _____

Provider Phone: _____ Provider Fax: _____

Prescriber _____ Prescriber NPI _____

CRITERIA

Member must be included in one of the following age groups at the beginning of the RSV season:

- Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly broncho-pulmonary dysplasia) who have required medical treatment (O₂, bronchodilator, diuretic, or corticosteroid therapy) for CLD in the 6 months prior to RSV season. Treatment/date received: _____
- Infants up to 24 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure.
- Infants less than 12 months of age, born at 28 weeks gestation or earlier
- Infants less than 6 months of age, born at 29-31 weeks gestation.
- Infants less than 12 months of age, born before 35 weeks gestation, with congenital abnormalities of the airway
- Infants less than 12 months of age, born before 35 weeks gestation, with severe neuromuscular disease
- Infants, up to 3 months old at the start of RSV season, born at 32-34 weeks gestation, who have one of the following risk factors:
 - o Child care attendance
 - o Siblings younger than 5 years of age

Additional Information: _____

Prescriber Signature (*Required*) _____ Date _____

Phone: _____ Fax: _____

Please Provide the Information Requested and Return to:
 UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
 PHARMACY MANAGEMENT CONSULTANTS
 PRODUCT BASED PRIOR AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4
 Toll Free 1-800-522-0114 Opt 4

FAX (405) 271-4014
 Toll Free 1-800-224-4014

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OKLA HCA Revised 09-10-10

Pharm-7

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICATION THERAPY MANAGEMENT SERVICES—MEMBER REFERRAL FORM

PART 1 — WAIVER VERIFICATION

Is the member enrolled in an Oklahoma Medicaid waiver program? Yes No

IF NO, STOP HERE.—The member is not eligible for Medication Therapy Management Services.

(To check a member's waiver status, please contact the OHCA Pharmacy Help Desk at (800) 522-0114, option 4 or (405) 522-6205, option 4.)

PART 2 — MEMBER INFORMATION

Member Name: Member ID Number: Date of Birth: / /

Is the member known to be allergic to any medications? Yes No

If yes, please list:

PART 3—MEDICATION PROFILE

Complete all information for each line. Include all medications the member is taking, including known OTC products.

	Medication Name / Strength	Regimen	Prescribing Physician	Diagnosis
1)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(If necessary, additional pages may be attached. Please include member name, ID number, and date of birth on all pages submitted.)

Please provide the requested information and return to:

University of Oklahoma College of Pharmacy Pharmacy Management Consultants Medication Therapy Management Services	<u>Fax</u> OKC Metro: (405) 271-6002 Toll Free: (866) 335-3331	<u>Phone</u> OKC Metro: (405) 271-6020 Toll Free (866) 837-6450
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Pharm-9
OKLA HCA
Revised 5-23-07



STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

**Statement of Medical Necessity for Brand-Name Drug
Override**

Pharmacy Management Consultants
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4
Fax: 405-271-4014 or 800-224-4014

After completing this form, please fax this form and any requested documentation to Pharmacy Management Consultants.
Please make sure that the member's ID Number is on every page faxed.

THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:

Member Name: _____	Member ID Number: _____
Member Date of Birth: _____	Dispensing Pharmacy Phone Number: _____
Dispensing Pharmacy Name: _____	Dispensing Pharmacy Fax Number: _____
Dispensing Pharmacy NPI: _____	Requested Drug Name & Strength: _____
Requested Drug NDC Number: _____	Requested Drug Monthly Quantity: _____
Requested Drug Dosing Regimen: _____	Requested Drug Fill Date: _____
Prescriber Name: _____	Prescriber NPI: _____
Prescriber Phone Number: _____	Prescriber Fax Number: _____

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:

Patient needs the requested brand-name drug rather than its FDA approved generic equivalent because:

Patient experienced an adverse event while using the generic medication.

The generic medication was not effective for the patient.

Other (Please explain): _____

Please answer the following questions about what happened when the patient took the generic medication:

- Generic medication taken** (Give labeled strength, mfr/labeler, lot #, & exp. date, if known):

- Dose, frequency, & route used:**

- Date(s) patient took the generic medication** (give from/to or best estimate):

- Diagnosis for use:**

Statement of Medical Necessity for Brand-Name Drug Override

Member ID
Number (REQUIRED):

5. Description of adverse event or problem:

6. How long after beginning use of drug did the event occur?

7. Outcomes attributed to adverse event caused by generic medication:

- Life-threatening Hospitalization – initial or prolonged Disability
- Intervention was required to prevent permanent impairment/damage
- Other: _____

8. Event abated after use stopped or dose reduced? Yes No Doesn't apply
If yes, how long after stopping or reducing dose of drug did event abate?

9. Event reappeared after reintroduction? Yes No Doesn't apply

10. Concomitant medical products & therapy dates: _____

11. Relevant Tests/Laboratory Data, Including Dates: _____

12. Other Relevant History, Including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.):

13. Patient's drug/excipient allergies:

14. Patient's Weight: _____

15. Patient's Height: _____

**** OHCA may request additional supporting documentation.****

Prescriber Signature: _____ Date: _____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.) <http://www.okhca.org>

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
Statement of Medical Necessity for Xolair

Pharmacy Management Consultants
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4
Fax: 405-271-4014 or 800-224-4014

After completing the request form please fax to Pharmacy Management Consultants to process this authorization.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN INFORMATION	CLIENT INFORMATION
Physician Name: _____	Client ID Number: _____
Address: _____	Patient Name: _____
City: _____ State: _____ Zip: _____	Address: _____
Phone () _____	City: _____ State: _____ Zip: _____
FAX () _____	Patient's date of birth: / /

Compliance with all of the prior authorization criteria is a condition for payment for this drug by Oklahoma Medicaid.

All information must be provided and Oklahoma Medicaid may verify through further requested documentation and the client's drug history will be reviewed prior to approval.

1. Detailed description of diagnosis: _____
2. Date diagnosed: _____
3. List daily medications and dose prescribed for the treatment of this diagnosis:
 Drug/Dose: _____ Drug/Dose: _____
 Drug/Dose: _____ Drug/Dose: _____
4. Was a spacer for inhaled medications used? ____ If 'No', why not? _____
5. Compliant on daily inhaled corticosteroids for a minimum of 3 months prior to request? _____
6. List frequency of: Exacerbations – Number ____ Per ____; AND Nightly Symptoms -- Number ____ Per ____
7. List place and dates of asthma related hospitalizations and/or ER visits in the past 6 months: _____

8. Patients weight: ____ kg; Baseline IgE Level: ____ IU/ml; Xolair Dose: _____
9. Asthma reaction due to food or peanut allergy? ____; Or List the perennial aeroallergen _____
10. Physician's specialty? _____

The above format is to assist the physician to provide medical documentation that Oklahoma Medicaid needs to review this request.

This information should come directly from the prescriber and **NOT** the pharmacy provider.

**** Please provide copies of medical documentation supporting the information above.**

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY LOCK-IN REFERRAL FORM

LOCK-IN UNIT PHONE: 1-800-522-0114 opt 4

LOCK-IN UNIT FAX: 1-866-335-3331

This form is used for referring members with possible medication over utilization to the Lock-in program to evaluate the need for possible lock-in to one pharmacy.

Referral Information	
Referral Source:	<input type="checkbox"/> Health Care Provider <input type="checkbox"/> ER Department <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Caseworker
Referral Name:	_____ Referral Phone: _____
Date of Referral:	_____

Member Information	
Member Name:	_____
Member ID:	_____
Member DOB:	_____

Reason for Referral	
<input type="checkbox"/> Multiple Pharmacies	<input type="checkbox"/> Multiple ER visits
<input type="checkbox"/> Multiple Prescribers	<input type="checkbox"/> Concern for Member Safety
<input type="checkbox"/> Other	
Description of referral reason: _____	



**State of Oklahoma
OKLAHOMA HEALTH CARE
AUTHORITY**

This form is provided to comply with 42 CFR 94.1.222
Formerly Okla. D.H.S.S. Issued 5-4-79

CONSENT FORM

NOTICE YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (doctor or clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (mm/dd/yyyy) _____.

I, _____, hereby consent of my own free will to be sterilized by (doctor) _____ by a method called _____.

My consent expires 180 days from that date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

Signature _____
Date _____

You are requested to supply the following information, but it is not required:

- Race and ethnicity designation (please check)
- American Indian or Alaska Native
 - Asian or Pacific Islander
 - Black (not of Hispanic origin)
 - Hispanic
 - White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter _____ Date _____

STATEMENT OF PERSON OBTAINING CONSENT

Before (name of individual) _____ signed the consent form, I explained to him/her the nature of the sterilization

operation, _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of person obtaining consent _____ Date _____

Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (name of individual) _____ on (date of sterilization) _____, I explained to him/her the nature of the sterilization operation (type of operation) _____ the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for alternative final paragraphs: Check the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph must be checked.

- 1. At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
- 2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
 - Premature delivery
 - Individual's expected date of delivery: _____
 - Emergency abdominal surgery (Describe circumstances): _____

Physician _____

Date _____



**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE
AUTHORITY**

Acknowledgement of Receipt of Hysterectomy Information

The Form is provided to meet the 42 CFR §441.2455 (c)(1)(2) Sterilization by hysterectomy and OAC: 317:30-5-19 Hysterectomies

Patient Name: _____

Address: _____

Telephone #: _____

OHCA/Medicaid #: _____

Physician: _____

Address: _____

* * *

Prior to surgery, I have been informed, both orally and in writing, that as a result of the hysterectomy, which is to be performed by the doctor named above, I will be permanently incapable of reproduction.

Patient Signature

Date



State of Oklahoma
OKLAHOMA HEALTH CARE AUTHORITY
CERTIFICATE FOR ABORTION

Patient Name: _____

Address: _____

Telephone: _____

Physician: _____

Address: _____

OHCA Provider #: _____

I certify that an abortion is necessary to save the life of the mother, or that the pregnancy is the result of an act of rape or incest.

Physician Signature

Date



STATE OF OKLAHOMA
Oklahoma Health Care Authority
Prior Authorization Request

Initial Request Additional Documentation
 Amended Photos/Videos Included

<p>SECTION I</p> <p>Prescribing Physician No.: _____ NPI / ZIP+4: _____ Physician Name: _____ Phone: () _____ Signature: _____ Date: _____</p>	<p>SECTION II</p> <p>Member RID: _____ Member Name: _____ Date of Birth: _____ Parent/Guardian: _____ Address: _____ City/State/Zip: _____ Phone: () _____</p>																																																																														
<p>SECTION III</p> <p>Estimated Length of Treatment: _____ Diagnosis Code(s): _____ Physician's Prescription: _____ _____ _____</p>																																																																															
<p>SECTION IV</p> <p>Servicing Prov. No. & Loc.: _____ NPI / ZIP+4: _____ Phone: () _____ Fax: () _____ Provider Name: _____ Address: _____ City/State/Zip: _____ Signature of Servicing Prov.: _____ Date: _____</p>	<p>SECTION V</p> <p>Date Span of Service From: _____ To: _____ Assignment Code (Select from below): _____ (01) Home Health (08) Audiology (26) Clinic (02) Hospital IP Facility or Hospital IP Physician (12) DME (37) Hospice (03) Hospital OP (17) Vision Care (40) High Risk OB (04) Physician (21) PD Nursing (46) Sleep Studies (06) Transplant (25) Lab and X-Ray</p>																																																																														
<p>SECTION VI - Do Not Skip Lines or PA will be Cancelled</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 5%;">LINE ITEM</th> <th style="width: 15%;">CPT, ICD or HCPCS Code</th> <th style="width: 10%;">MODIFIER</th> <th style="width: 40%;">DESCRIPTION (Must Be On One Line)</th> <th style="width: 10%;">TOTAL UNITS FOR DATE SPAN</th> <th style="width: 10%;">TOTAL BILLED CHARGES</th> </tr> </thead> <tbody> <tr><td>A</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>B</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>C</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>D</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>E</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>F</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>G</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>H</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>I</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>J</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>K</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>L</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>		LINE ITEM	CPT, ICD or HCPCS Code	MODIFIER	DESCRIPTION (Must Be On One Line)	TOTAL UNITS FOR DATE SPAN	TOTAL BILLED CHARGES	A						B						C						D						E						F						G						H						I						J						K						L					
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FORWARD TO: Attn: Prior Authorization, 4345 N Lincoln, Oklahoma City, OK 73105
 OR FAX: (405) 702-9080 Toll Free: 1-866-574-4991

OHCA Revised: 08/28/2014

HCA-12A



**Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet**

Three fields below are required and must match claim.

- 1. Provider Number**
- 2. Client ID Number**
- 3. Attachment Control Number**

Purpose:

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number that was used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numeric are the only characters that should be used in ACN selection. Do not use dashes and spaces in ACNs.
4. Place this completed form on top of the attachment(s) for each electronic claim.
5. Mail to EDS, P.O. Box 18500 OKC, OK. 73154, fax 405-947-3394.

Note: Do not place another fax cover sheet on top.

***This form is for use with electronically filed claims requiring attachments.**

Sender's Name: _____ Phone Number: _____

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.

OKLA HCA
REVISED 09/24/13

HCA-13



Prior Authorization Attachment Form Cover Sheet

- Initial Request
 Amended
 Additional Documentation
 Photos/Videos Included

Note: Do not place another Fax Cover Sheet on top.

Three fields below are required and must match the prior authorization request.

1. **Provider Number or NPI/ZIP/ZIP+4:**
2. **Member ID Number:**
3. **Prior Authorization Number:**

Purpose:

This form is to be used when a prior authorization request (PAR) requiring a paper attachment is being submitted. Submission of the completed forms along with the required attachments will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. Box 1; fill in the Servicing Provider Number.
2. Box 2; fill in the nine-digit member identification number.
3. Box 3; write "new" to initiate a new prior-authorization request. A "new" PAR is also required for continuation of previously authorized services. PAR dates must not overlap previously approved dates of service.
 - a. For SoonerCare or Insure Oklahoma online PAR submissions, enter the corresponding PAR number in box 3.
 - b. **To submit additional documentation or to amend a PAR, enter the existing PAR number in box 3 to assure your documentation will be linked with the correct existing PAR.**
4. The Initial Request box is to be checked when requesting "new" services.
5. The Amended box is to be checked when minor changes are required to an existing approved authorization. Also, enter the prior authorization number in box 3 above so your amendment request will be linked with the correct existing PAR.
6. The Additional Documentation box is to be checked when submitting additional documentation to be added to an existing PAR. Enter the PAR number in box 3 above so your documentation will be linked with the correct existing PAR.
7. The Photos/Videos Included box is to be checked when submitting photos or videos for review. Mail to: HP Attn: Prior Authorizations, 2401 NW 23rd, Suite 11, Oklahoma City, OK, 73107
8. Fax all forms and documentation to: **405-702-9080 Toll Free 1-866-574-4991**

Note: Do not place another Fax Cover Sheet on top.

This form is for use with Prior Authorization requests requiring attachments.

Sender's Name: **Phone Number:**

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.

OHCA Revised 05/8/2014

HCA-13A



**UB04 AND INPATIENT/OUTPATIENT
CROSSOVER ADJUSTMENT REQUEST**

Mail completed requests to: OHCA - Adjustments, 4345 N. Lincoln, Oklahoma City, OK 73105

(1) PROVIDER NUMBER: PROVIDER NAME/ADDRESS: <div style="background-color: #cccccc; height: 30px; width: 100%;"></div> PHONE NUMBER: CONTACT PERSON:		(2) REASON FOR ADJUSTMENT: (Check appropriate Box) <input type="checkbox"/> Change TPL Amt. <input type="checkbox"/> Change Patient LIABILITY (Attach all EOMB's that apply) <input type="checkbox"/> Offset or Refund of entire claim amount (check block 10) <input type="checkbox"/> Change information as indicated in blocks 13-16 <input type="checkbox"/> Medicare Adjustment (Attach all EOMB's that apply to this adjustment)	
(3) CLAIM NUMBER (ICN):	(4) Client ID NO.:	(5) DATE OF SERVICE: From: Thru:	
(6) Client NAME:	(7) AMOUNT PAID:	(8) REMITTANCE ADVISE DATE:	
(9) TYPE OF ADJUSTMENT <input type="checkbox"/> Underpayment Adjustment <input type="checkbox"/> Overpayment Adjustment (Deduct from future payments) <input type="checkbox"/> Refund Adjustment (Check attached) Check number:		(10) CLAIM TYPE <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Long Term Care <input type="checkbox"/> Home Health <input type="checkbox"/> Crossover	(11) MEDICAID PROGRAM <input type="checkbox"/> Fee for Service <input type="checkbox"/> SoonerCare Choice <input type="checkbox"/> SoonerCare Plus
(12) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:			
LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)			
(13) REV/PROC CODE:	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

17) SIGNATURE: _____ **(18) DATE:** _____

Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299

A completed adjustment request form is **required for each claim** you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

- | | | |
|-----------|--------------------------------|---|
| 1 | PROVIDER NUMBER: | Enter your 9 digit billing provider number and 1 character service location |
| | PROVIDER NAME/ADDRESS | Enter your current billing name and address |
| | PHONE NUMBER: | Enter phone number of the contact person |
| | CONTACT NAME: | Enter a contact name |
| 2 | REASON FOR ADJUSTMENT: | Check the appropriate box for the reason you are requesting an adjustment |
| 3 | CLAIM NUMBER (ICN): | Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (Use the most current ICN for the claim to be adjusted.) |
| 4 | CLIENT ID NO.: | Enter the recipient's 9 digit identification number |
| 5 | DATES OF SERVICE: | Enter the From and Thru Dates of Service as billed on the claim |
| 6 | CLIENT NAME: | Enter the First and Last Name of the Recipient |
| 7 | AMOUNT PAID: | Enter the Paid Amount of the claim to be adjusted |
| 8 | REMITTANCE ADVICE DATE: | Enter the date of your Remittance Advice on which the claim last paid |
| 9 | TYPE OF ADJUSTMENT: | <p>Check the appropriate box for the type of adjustment you are requesting:</p> <p>* Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment.</p> <p>* Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion of the claim or the entire amount of the claim.)</p> <p>* Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)</p> |
| 10 | CLAIM TYPE | Check the appropriate box of the claim type to be adjusted. |
| 11 | PROGRAM | Check the appropriate box of the program to which the claim to be adjusted is associated. |
| 12 | EXPLANATION | Give a clear explanation for the requested adjustment or refund |
| 13 | REV/PROC CODE | Enter the number of the line that data is to be adjusted. If the adjusted data is not associated to a specific line on the claim, enter a zero (0) in this field |
| 14 | DESCRIPTION | Enter a brief description of the data that is to be corrected on the claim |
| 15 | CURRENT INFO | Enter the information as stated on the current claim that is to be adjusted |
| 16 | CORRECTED INFO | Enter the corrected information for the claim |
| 17 | SIGNATURE | Enter signature of appropriate person (physician, billing clerk, etc. – not required) Enter |
| 18 | DATE | the date you are submitting this request (Required) |



CMS-1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST

Mail completed requests to: OHCA - Adjustments, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105
 Mail Refunds to: OHCA- Finance, P.O. Box 18299, Oklahoma City, OK 73154-0299

<p>1) PROVIDER NUMBER: _____</p> <p>PROVIDER NAME/ADDRESS: _____</p> <p>PHONE NUMBER: _____</p> <p>CONTACT PERSON: _____</p>	<p>(2) REASON FOR ADJUSTMENT: (Check appropriate Box)</p> <p><input type="checkbox"/> Change TPL Amt. (Attach all EOMB's that apply)</p> <p><input type="checkbox"/> Offset or Refund of entire claim amount (check block 10)</p> <p><input type="checkbox"/> Change information as indicated in blocks 13-16</p> <p><input type="checkbox"/> Medicare Adjustment (Attach all EOMBs that apply to this adjustment)</p>
--	--

(3) CLAIM NUMBER (ICN)	(4) CLIENT ID NO.	(5) DATE OF SERVICE From: _____ Thru: _____
--------------------------------	--------------------------	---

(6) CLIENT NAME	(7) AMOUNT PAID	(8) REMITTANCE ADVICE DATE
------------------------	------------------------	-----------------------------------

(9) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

<p>(10) TYPE OF ADJUSTMENT</p> <p><input type="checkbox"/> Underpayment Adjustment</p> <p><input type="checkbox"/> Overpayment Adjustment (Deduct from from future payments)</p> <p><input type="checkbox"/> Refund Adjustment (Check attached)</p> <p>Check number: _____</p>	<p>(11) CLAIM TYPE</p> <p><input type="checkbox"/> Dental</p> <p><input type="checkbox"/> Crossover</p> <p><input type="checkbox"/> CMS-1500</p>	<p>(12) MEDICAID PROGRAM</p> <p><input type="checkbox"/> Fee for Service</p> <p><input type="checkbox"/> SoonerCare</p>
---	---	--

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) LINE NO.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

17) SIGNATURE: _____ **(18) DATE:** _____

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
CMS-1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST INSTRUCTIONS

A completed adjustment request form is **required for each claim** you are requesting to be adjusted. In addition, a copy of the Remittance Advice and a copy of the corrected claim will also facilitate the adjustment process. If the adjustment request is for a Crossover claim attach a copy of the Medicare EOMB or if the request is for an adjustment to the TPL amount attach a copy of the insurance EOMB.

- | | | |
|-----------|-------------------------------|---|
| 1 | PROVIDER NUMBER | Enter your 9 digit billing provider number and 1 character service location |
| | PROVIDER NAME/ADDRESS | Enter your current billing name and address |
| | PHONE NUMBER | Enter phone number of contact person |
| | CONTACT NAME | Enter a contact name |
| 2 | REASON FOR ADJUSTMENT | Check the appropriate box for the reason you are requesting an adjustment |
| 3 | CLAIM NUMBER (ICN) | Enter the Internal Control Number of the claim you wish to adjust. This can be found on the Remittance Advice. (Use the most current ICN for the claim to be adjusted.) |
| 4 | CLIENT ID NO. | Enter the recipient's 9 digit identification number |
| 5 | DATES OF SERVICE | Enter the From and Thru Dates of Service as billed on the claim |
| 6 | CLIENT NAME | Enter the First and Last Name of the Recipient |
| 7 | AMOUNT PAID | Enter the Paid Amount of the claim to be adjusted |
| 8 | REMITTANCE ADVICE DATE | Enter the date of your Remittance Advice on which the claim last paid |
| 9 | EXPLANATION | Give a clear explanation for the requested adjustment or refund |
| 10 | TYPE OF ADJUSTMENT | <p>Check the appropriate box for the type of adjustment you are requesting:</p> <p>* Underpayment – An adjustment to a claim in which you are requesting additional payment, or for which you are requesting a change to the claim's data which will result in no net change in payment.</p> <p>* Overpayment – An adjustment to a claim for which you are requesting that an overpaid amount be deducted from your future payments. (This may be a recoupment of a portion of the claim or the entire amount of the claim.)</p> <p>* Refund – Same as overpayment except that you are submitting a refund check for the overpaid amount. (A refund may be applied to a portion of the claim or to the entire amount of the claim.)</p> |
| 11 | CLAIM TYPE | Check the appropriate box of the claim type to be adjusted. |
| 12 | PROGRAM | Check the appropriate box of the program to which the claim to be adjusted is associated. |
| 13 | LINE NO. | Enter the number of the line that data is to be adjusted. If the adjusted data is not associated to a specific line on the claim, enter a zero (0) in this field |
| 14 | DESCRIPTION | Enter a brief description of the data that is to be corrected on the claim |
| 15 | CURRENT INFO | Enter the information as stated on the current claim that is to be adjusted |
| 16 | CORRECTED INFO | Enter the corrected information for the claim |
| 17 | SIGNATURE | Enter signature of appropriate person (physician, billing clerk, etc. – not required) |
| 18 | DATE | Enter the date you are submitting this request (Required) |

**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
CLAIM INQUIRY FORM**

Attach a red & white, one-page claim form and any applicable documentation. If you have previously sent a claim for review, please be sure to include additional documentation not previously sent to support your request. Please include detailed processing instructions in the Inquiry field. Return the completed form to the address below. A completed form is required for each submitted claim.

SEND COMPLETED FORM TO:
Attn: Provider Services
Oklahoma Health Care Authority
PO Box 18506, Oklahoma City, OK 73154

FORM MUST BE PLACED ON TOP OF CLAIM

PROVIDER INFORMATION

Name & Address:	Provider Number: _____ Group Number (if applicable): _____ Telephone: _____ Contact Name: _____ <p style="text-align: right; font-size: small;">Please print.</p>
-----------------	---

CLAIM INFORMATION

Member Name	Member ID Number	Date of Service	Related ICN
INQUIRY: (Please list specific reasons why claim needs/requires special processing.)			
Printed Name: _____			Date:
Signature: _____			

For Internal Use Only

**FORM MUST
BE PLACED ON
TOP OF CLAIM**



Request for Duplicate Provider Remittance Statement

Please complete one form per request and include \$5.00 non-cash payment per request if the Remittance Statement is beyond 60 days or if requesting a copy of the electronic Remittance Statement. Mail completed form(s) and payment to:

Oklahoma Health Care Authority
ATTN: Central Files
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Provider Name (Last, First, MI): _____
*Provider Billing Number: _____
Mailing Address (with zip code): _____

Contact Person: _____
Telephone Number (with extension) _____

Paid Claims: (Complete A or B)

A.
Warrant #: _____
Issue Date: _____
*Pay to Provider Number: _____

B.
Deposit Date: _____
Deposit Amount: _____
*Pay to Provider Number: _____

Denied Claims:

Medicaid Client ID #: _____
Date of the Service: _____
*Pay to Provider Number: _____ Date of Denial: _____

If you filed your claim via Electronic Media (EMC), please include EMC transmittal #: _____

*** Provider Numbers as of Date of Service**

Incomplete requests will be returned.
As stated under the Federal Privacy Act, information will not be released to collection agencies.

Please allow 3-4 weeks for response.

Agency Use:
Date Received/Initial: _____ / _____
Date Completed: _____
Check Number: _____
Mailed: _____



STATE OF OKLAHOMA
Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, OK 73105 (405) 522-7300

Authorization to Release Medicaid Records

Client Name: _____ **Client ID#:** _____ **DOB:** _____

1. I authorize the OHCA to release the above individual's Medicaid information as described below.

2. I understand the information in my Medicaid record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. This information may be released to the following:

Name: _____

Address: _____

Phone: _____ FAX: _____

4. For the purpose of:

5. I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to OHCA. I understand that information may have already been released based on this authorization. Unless changed, this authorization will expire on the following date: _____. If I don't put a date, this authorization will expire in six months.

6. I understand that signing this release is voluntary, and a refusal to sign does not affect my receipt of Medicaid services. I may inspect or obtain a copy of the information to be released.

Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

Signature of Patient or Legal Representative *(Legal representative must show relationship to patient):*

X _____ **Date:** _____

Relationship to patient _____

Signature of Witness

X _____ **Date:** _____



ESTADO DE OKLAHOMA
Oklahoma Health Care Authority
 2401 N.W. 23rd Street, Suite 1A
 Oklahoma City, OK 73107 (405) 522-7300

Autorización para revelar registros de Medicaid

Nombre del cliente: No. de identificación del cliente:
 Fecha de nacimiento:

1. Autorizo a la OHCA para revelar la información de Medicaid del individuo arriba mencionado, según lo descrito abajo.

2. Comprendo que la información de mi registro de Medicaid puede incluir información relacionada con enfermedades transmitidas sexualmente, el síndrome de inmunodeficiencia adquirido (SIDA) o el virus de inmunodeficiencia humana (VIH). También pueden incluir información sobre servicios de salud mental o conductual y tratamiento de abuso de drogas o alcohol.

3. Esta información se le puede revelar a: Nombre:
 Dirección:
 Teléfono: FAX:

4. Con el fin de:

5. Comprendo que puedo modificar esta autorización en cualquier momento. Comprendo que esta autorización se deberá modificar por escrito ante la OHCA. Comprendo que ya puede haberse divulgado información basada en esta autorización. A menos que se modifique, esta autorización tendrá vigencia hasta la siguiente fecha:

Si no escribo una fecha, la autorización tendrá vigencia de seis meses.

6. Comprendo que la firma de esta autorización de divulgación de información es voluntaria y que el negarme a firmar no afectará la recepción de mis servicios de Medicaid. Podré inspeccionar u obtener copia de la información que será revelada.

Bajo penade ley, declaro que soy, de hecho, el suscrito o su representante legal. Firma del paciente o del representante legal (El representante legal debe anotar su parentesco con el paciente):

X _____ Fecha:

Parentesco con el paciente:

X _____ Fecha:

OKLA.HCA Revised 11-15-2010 HCA-20 Spanish

STATE OF OKLAHOMA SOONERCARE Population Care Management Referral Form					
Population Care Management Phone 1-877-252-6002		Population Care Management Fax 405-530-3217			
Referral Date: _____	Date PCM Referral Received: _____				
		Received by: _____			
		Referral Source Notified of Receipt: <input type="checkbox"/> Yes			
Referral Information					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Referral Source: <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Specialty Provider <input type="checkbox"/> ER Department </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Caseworker/DC Planner <input type="checkbox"/> Community Agency <input type="checkbox"/> Transition Coordinator <input type="checkbox"/> Other (define): _____ </td> </tr> </table>				Referral Source: <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Specialty Provider <input type="checkbox"/> ER Department	<input type="checkbox"/> Caseworker/DC Planner <input type="checkbox"/> Community Agency <input type="checkbox"/> Transition Coordinator <input type="checkbox"/> Other (define): _____
Referral Source: <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Specialty Provider <input type="checkbox"/> ER Department	<input type="checkbox"/> Caseworker/DC Planner <input type="checkbox"/> Community Agency <input type="checkbox"/> Transition Coordinator <input type="checkbox"/> Other (define): _____				
Referral Name: _____		Referral Phone (Direct line preferred): _____			
Member Information					
Member Name: _____		Member ID: _____			
Member DOB: _____		Member Phone: _____			
Contact Name: _____		Contact Phone: _____			
Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Other (specify) _____					
Reason for Referral (Check all that apply)					
Chronic and Complex Care Support					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Member has chronic condition and is at risk for poor outcome (Diabetes, Asthma, CAD, Hypertension, Hemophilia, Sickle Cell Anemia, Other) Please circle applicable conditions <input type="checkbox"/> Member has multiple inpatient admissions <input type="checkbox"/> Member is child with special health care needs; require assistance with care <input type="checkbox"/> Other Chronic Care concerns (specify) _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Member is overweight and desires support in losing weight <input type="checkbox"/> Member uses tobacco and desires support in tobacco cessation <input type="checkbox"/> Member has complex discharge needs <input type="checkbox"/> Member needs education regarding condition </td> </tr> </table>				<input type="checkbox"/> Member has chronic condition and is at risk for poor outcome (Diabetes, Asthma, CAD, Hypertension, Hemophilia, Sickle Cell Anemia, Other) Please circle applicable conditions <input type="checkbox"/> Member has multiple inpatient admissions <input type="checkbox"/> Member is child with special health care needs; require assistance with care <input type="checkbox"/> Other Chronic Care concerns (specify) _____	<input type="checkbox"/> Member is overweight and desires support in losing weight <input type="checkbox"/> Member uses tobacco and desires support in tobacco cessation <input type="checkbox"/> Member has complex discharge needs <input type="checkbox"/> Member needs education regarding condition
<input type="checkbox"/> Member has chronic condition and is at risk for poor outcome (Diabetes, Asthma, CAD, Hypertension, Hemophilia, Sickle Cell Anemia, Other) Please circle applicable conditions <input type="checkbox"/> Member has multiple inpatient admissions <input type="checkbox"/> Member is child with special health care needs; require assistance with care <input type="checkbox"/> Other Chronic Care concerns (specify) _____	<input type="checkbox"/> Member is overweight and desires support in losing weight <input type="checkbox"/> Member uses tobacco and desires support in tobacco cessation <input type="checkbox"/> Member has complex discharge needs <input type="checkbox"/> Member needs education regarding condition				
Utilization Management/ Acute Care Support					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Member is pregnant and is at risk for poor outcome <input type="checkbox"/> Member has had multiple ER visits <input type="checkbox"/> Member has Poly-pharmacy issues <input type="checkbox"/> Member may need access to Out of State Care <input type="checkbox"/> Other concerns (specify) _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Member has education needs related to benefits <input type="checkbox"/> Member needs access to community resources <input type="checkbox"/> Member needs access to specialty services <input type="checkbox"/> Member needs Living Choice Assessment </td> </tr> </table>				<input type="checkbox"/> Member is pregnant and is at risk for poor outcome <input type="checkbox"/> Member has had multiple ER visits <input type="checkbox"/> Member has Poly-pharmacy issues <input type="checkbox"/> Member may need access to Out of State Care <input type="checkbox"/> Other concerns (specify) _____	<input type="checkbox"/> Member has education needs related to benefits <input type="checkbox"/> Member needs access to community resources <input type="checkbox"/> Member needs access to specialty services <input type="checkbox"/> Member needs Living Choice Assessment
<input type="checkbox"/> Member is pregnant and is at risk for poor outcome <input type="checkbox"/> Member has had multiple ER visits <input type="checkbox"/> Member has Poly-pharmacy issues <input type="checkbox"/> Member may need access to Out of State Care <input type="checkbox"/> Other concerns (specify) _____	<input type="checkbox"/> Member has education needs related to benefits <input type="checkbox"/> Member needs access to community resources <input type="checkbox"/> Member needs access to specialty services <input type="checkbox"/> Member needs Living Choice Assessment				
Please describe your concerns and reason for referral / desired outcome: <div style="border: 1px solid black; height: 80px; width: 100%;"></div>					



Medicare to Medicaid Crossover Invoice

Do **NOT** USE THIS FORM FOR HMO COPAY OR THIRD PARTY LIABILITY CLAIM SUBMISSIONS

One invoice per claim

Field Description for Medicare-Medicaid Crossover Invoice

Form Locator	HCA – 28 Form
Sooner Care Provider ID:	Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider. <i>Required.</i>
Member ID	Enter the member's SoonerCare identification number. Must be nine digits. <i>Required.</i>
Patient Control Number	Patient's Account Number – Enter your internal patient tracking number. The tracking number should be the same as the submitted claim. <i>Optional.</i>
Medicare HIC Number	Enter the Patient's Medicare HIC Number. The Medicare HIC Number should be the same number as submitted on the claim. <i>Required.</i>
Dates of Service	Enter the From and To Dates of Service as MM/DD/YYYY. <i>Required.</i>
Total Billed	Enter the Amount Billed from the Medicare Explanation of Benefits. <i>Required.</i>
Date Paid	Enter the Date Paid as MM/DD/YYYY from the Medicare Explanation of Benefits. <i>Required.</i>
Coinsurance	Enter the Coinsurance Amount from the Medicare Explanation of Benefits. <i>Required, if applicable.</i>
Coinsurance Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable.</i>
Deductible	Enter Deductible Amount from the Medicare Explanation of Benefits. <i>Required, if applicable.</i>
Deductible Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable.</i>
Blood Deductible	Enter the Blood Deductible from the Medicare Explanation of Benefits. <i>Required, if applicable.</i>
Total Allowed	Enter the Amount Allowed from the Medicare Explanation of Benefits. <i>Required, if applicable.</i>
Total Allowed Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable.</i>
Amount Paid	Enter the Amount Paid from the Medicare Explanation of Benefits. <i>Required, if applicable.</i>
Amount Paid Remark Code	Only enter Remarks PR-122 or MA 67. <i>Required, if applicable.</i>
Provider Signature	Signature of Physician or Supplier– The name of the authorized person, someone designated by the agency or organization. <i>Required.</i>
Date Signed	Enter date the claim was signed as MM/DD/YYYY. <i>Required</i>

19-04 CMS-1450

1		2		3a. PAT. CNTRL. #		4. TYPE OF BILL	
				b. MED. REC. #			
				5. FED. TAX NO.		6. STATEMENT COVERS PERIOD FROM	
						7. THROUGH	
8. PATIENT NAME		9. PATIENT ADDRESS					
b		b		c		d	
10. BIRTHDATE		11. SEX		12. DATE		13. HR	
		14. TYPE		15. SRC		16. DHR	
		17. STAT		18		19	
		20		21		22	
		23		24		25	
		26		27		28	
		29		30		31	
31. OCCURRENCE CODE		32. OCCURRENCE DATE		33. OCCURRENCE CODE		34. OCCURRENCE DATE	
				35. OCCURRENCE CODE		36. OCCURRENCE SPAN FROM	
						37. OCCURRENCE SPAN THROUGH	
						38	
				39. VALUE CODES		40. VALUE CODES	
				41. VALUE CODES		42. VALUE CODES	
				43. VALUE CODES		44. VALUE CODES	
43. REV. CD.		44. DESCRIPTION		44. HCPCS / RATE / HIPPS CODE		45. SERV. DATE	
						46. SERV. UNITS	
						47. TOTAL CHARGES	
						48. NON-COVERED CHARGES	
						49	
PAGE		OF		CREATION DATE		TOTALS	
50. PAYER NAME		51. HEALTH PLAN ID		52. REL. INCL.		53. PRIOR PAYMENTS	
				54. PRIOR PAYMENTS		55. EST. AMOUNT DUE	
						56. NPI	
						57. OTHER PRV ID	
58. INSURED'S NAME		59. PHEL		60. INSURED'S UNIQUE ID		61. GROUP NAME	
						62. INSURANCE GROUP NO.	
63. TREATMENT AUTHORIZATION CODES		64. DOCUMENT CONTROL NUMBER		65. EMPLOYER NAME			
66. DX		67. A		68. B		69. C	
69. ADMIT DX		70. PATIENT REASON DX		71. FPS CODE		72. ECG	
74. PRINCIPAL PROCEDURE CODE		75. OTHER PROCEDURE CODE		76. OTHER PROCEDURE CODE		77. OTHER PROCEDURE CODE	
						78. ATTENDING NPI	
						QUAL	
						LAST	
						FIRST	
						77. OPERATING NPI	
						QUAL	
						LAST	
						FIRST	
						78. OTHER NPI	
						QUAL	
						LAST	
						FIRST	
						79. OTHER NPI	
						QUAL	
						LAST	
						FIRST	
80. REMARKS		81. ICD		82. ICD		83. ICD	
		a		b		c	
		d		e		f	

LIB-04 CMS-1450 APPROVED OMB NO. 0938-0997

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																			
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					7. INSURED'S ADDRESS (No., Street)														
ZIP CODE					TELEPHONE (Include Area Code)					CITY					STATE														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>														
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)					b. OTHER CLAIM ID (Designated by NUCC)														
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME														
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																													
SIGNED _____										DATE _____										SIGNED _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____										15. OTHER DATE MM DD YY QUAL _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										A. _____ B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____									
E. _____ F. _____ G. _____ H. _____										I. _____ J. _____ K. _____ L. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1										2										3									
4										5										6									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. claims, use back) YES <input type="checkbox"/> NO <input type="checkbox"/>									
28. TOTAL CHARGE \$ _____										29. AMOUNT PAID \$ _____										30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()									
SIGNED _____										DATE _____										a. NPI _____ b. _____									

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																								
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																								
2. Predetermination/Preauthorization Number																								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																								
3. Company/Plan Name, Address, City, State, Zip Code																								
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)					16. Plan/Group Number					17. Employer Name														
					5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)					18. Relationship to Policyholder/Subscriber in #12/Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other					19. Reserved For Future Use									
6. Date of Birth (MM/DD/CCYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code														
9. Plan/Group Number			10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other					21. Date of Birth (MM/DD/CCYY)					22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																								
RECORD OF SERVICES PROVIDED																								
24. Procedure Date (MM/DD/CCYY)		25. Area of Oral Cavity		26. Tooth System		27. Tooth Number(s) or Letter(s)		28. Tooth Surface		29. Procedure Code		29a. Diag. Pointer		29b. Cof		30. Description		31. Fee						
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
33. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)					31a. Other Fee(s)									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____								
31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		34b. (Primary diagnosis in "A") B _____ D _____								
35. Remarks										32. Total Fee					\$0.00									
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION														
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										38. Place of Treatment <input type="checkbox"/> (e.g. 11-office; 22-C/P Hospital) (Use "Place of Service Codes for Professional Claims")					39. Enclosures (Y or N) <input type="checkbox"/>									
X Patient/Guardian Signature _____ Date _____										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					41. Date Appliance Placed (MM/DD/CCYY)									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										42. Months of Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					44. Date of Prior Placement (MM/DD/CCYY)				
X Subscriber Signature _____ Date _____										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident														
46. Date of Accident (MM/DD/CCYY)										47. Auto Accident State														
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION														
48. Name, Address, City, State, Zip Code										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.														
49. NPI										50. License Number					51. SSN or TIN									
52. Phone Number										52a. Additional Provider ID					57. Phone Number					58. Additional Provider ID				
54. NPI										55. License Number					56. Address, City, State, Zip Code					56a. Provider Specialty Code				

State of Oklahoma
Oklahoma Health Care Authority
SoonerCare/OEPIC IP Referral Form

Please Print

Member Name
Last Name First Name Middle Initial

Member ID# Member
(nine digits) Phone #

Referred To:

Provider Name Provider
(Must be a current Medicaid Provider) Phone #

Provider Address

PCP/CM Referral Valid Initial Visit Only Evaluation & Treatment for _____ months (cannot
for (check one) exceed 12 months)

Reason for Referral:

Referred by:

Primary OR Case PCP/CM
Care Manager Provider Name Phone #

PCP/CM # Referral NPI #
Number (ten digits)

Provider Address

Signature of Referring Date
Provider

- * This referral is valid for all ancillary services related to the above diagnosis within the specified time frame.
- * This referral may be forwarded to other specialists for the above diagnosis with the approval of the PCP/CM.
- * Report your findings directly to the provider who made this referral.
- * This referral number should be entered by the referred to provider in Block 17a and NPI in Block 17b of the CMS-1500 claim form or Block 30 of the UB 4 claim form.
- * This form is for referral only. It does not replace the prior authorization form. Some services for **SoonerCare/OEPIC IP** clients require (1) PCP/CM referral **and** (2) prior authorization from the Medical Authorization Unit at Oklahoma Health Care Authority. The current prior authorization policies are unchanged (See Oklahoma Health Care Authority Rules).
- * All payments for services are subject to coverage limitations under the current Medicaid/OEPIC IP program and the referral is not a guarantee of payment.

Instructions:

1. Complete and mail the original copy of the form to the provider to whom you are referring.
2. Keep a duplicate copy for your records in the member's medical chart.
3. Referral form (SC-10) may be obtained on the OHCA web site at <http://www.okhca.org/provider/forms.asp>

PLEASE DO NOT MAIL OR FAX A COPY TO OHCA.
PLEASE DO NOT ATTACH A COPY TO YOUR CLAIM FORM.



**Change of Provider
Prior Authorization Form**

Member Name: _____
Member RID #: _____
Service Being Rendered: _____

I (print name of member/parent/legal guardian) _____
 hereby wish to change the above listed services being provided by
 (print name of previous provider) _____
 to (print name of New provider) _____
 effective _____ (date the change is to take place).

 Signature of Member of Parent/Legal Guardian if a minor

 Date Signed by Member/Parent/Legal Guardian

 Relationship to Member

****Please Note: Form must be completed in its entirety or will be considered incomplete and will not be accepted. Also, the effective date of change will depend on current billing cycle.****

ESTADO DE OKLAHOMA
Autoridad de Oklahoma para el Cuidado de la Salud
Cambio de Proveedor
Formulario de Autorización Previa

Nombre del miembro: _____

ID de registro del miembro: _____

Servicio prestado: _____

Yo, _____ (nombre en letra de imprenta del miembro/padre/madre/tutor legal), por la presente deseo cambiar los servicios que se enlistan arriba y que presta _____ (nombre en letra de imprenta del proveedor anterior) a _____ (nombre en letra de imprenta del nuevo proveedor) a partir del _____ (fecha en que el cambio tendrá lugar).

Firma del miembro o padre/madre/tutor legal si es menor de edad

Fecha con firma del miembro/padre/madre/tutor legal

Relación con el miembro

******Tenga en cuenta: El formulario debe completarse en su totalidad; de lo contrario, se considerará incompleto y no será aceptado******

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